PHM / SR8 – 53 (RB2)

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A Report from the PHM Secretariat (Global)

Presented at JSA – NCC / NWG (PHM – India) planning meeting in Bangalore, on 27th July 2003.

1. Background:

- After the PHM Secretariat (Global) had been hosted by GK – Savar (South Asia Region) for two year (December 2000 till December 2002), it was decided by the core group/ Steering group of PHM (in November 2001) to request another region to host it for the next 2 years, so that the focus and coordinating responsibility would be shared by the region.
- After consultations at different levels and for over an year, PHM – India region agreed to host it and in Bhopal in July 2002, it was endorsed that CHC Bangalore (one of the 18 founding networks of PHM – India), would host the secretariat (see minutes)
- This was ratified at the PHM Global Steering Group meeting in November 2002. At this meeting, it was decided that there would be a 3-month phase of gradual transition, January – March 2003, when both GK Savar (Dr. Qasem Chowdhury) and CHC (Dr. Ravi Narayan) would be coordinators (outgoing and incoming respectively).
- In January 2003, soon after the Asia Social Forum in Hyderabad, Dr. Qasem Chowdhury (GK – Savar) and Dr. Prem Chandra John (ACHAN) visited the CHC, Bangalore to assess the situation and help with the transition. Olle Nordberg (DHF) also visited CHC soon after for the same purpose. All three are also members of the PHM funding group. A tentative one year project proposal and budget was evolved.

2. Infrastructure / Facilities:

- To keep the identify of the PHM Secretariat distinct from CHC, Bangalore, it was decided to take additional premises as close to CHC as possible. CHC advanced the deposit of 1.25 lakhs for the same and provided the basic furniture, computers and other office support.
- A separate telephone line was arranged (080-51280009) with Internet link.

3. Secretariat Team:

- Dr. Ravi Narayan, Community Health Adviser of CHC and Mr. D.G. Srinidhi, Office Secretary of CHC and Mr. C. James, Office / Media Assistant of CHC were officially deputed by a CHC – EC decision to the PHM Secretariat for a period of 2 years from January 2003 or till required/
- Mr. S.S. Prasanna was newly appointed as a Communication Officer from January 20th 2003.
- A Technical Officer – (recommended by the PHM Funding group) was not appointed straightaway, since as a trial it was felt that CHC team members and fellows would provide this support initially and also PHM Steering group members would be invited to support the process technically. It was decided to assess the situation after 6 months.
- At the Bhopal meeting (July 2002) of the JSA, it was also decided that a four member PHM – JSA secretariat support / link group would help Dr. Ravi with the secretariat transition and support. This included Dr. B. Ekbal and Dr. Mira Shiva (both PHM Global

Steering group members) and Dr. Amit Sengupta (Joint Convener) and Dr. Mohan Rao, both PHM – JSA members.
[All correspondences to PHM Steering group members is also marked to this four member link / support group regularly)

4. Secretariat Support Group:

Over the first few months, the coordinator (Ravi Narayan) established a good working relationship with a large network of PHM resource persons including some on the Steering group and evolved the following framework of support for the secretariat – as a global networking effort).

These include:

a. PHM funding group – Qasem Chowdhury (GK); Prem John (ACHAN); Olle Nordberg (DHF); Bala (HAI – AP); Maria Hamlin Zuniga (IPHC); Andy Rutherford (One World Action)
b. PHM Communications:

i. Communication and Website :	Andrew Chetley (UK); Nand (Costa Rica)
ii. Media:	Unnikrishnan (India); Satya Sivaraman (Bangkok)
iii. PHM Exchange:	Claudio Schuftan (Vietnam)
iv. News Brief:	Prem John (India); Qasem Chowdhury (Bangladesh); Hani Serag (Egypt).

The PHM office at GK Savar was continued as a small PHM Resource Center to continue to facilitate News brief and publications and also serve as PHM archival center. (See Appendix A).

5. Steering / Planning / Strategy:

- A Steering group consisting of representatives of the 8 founding networks and the 13 regions (into which the countries represented at PHA – I were divided by a PHM Core group decision in November 2001) and the outgoing and incoming coordinators was formalized at the PHM Core Group / Steering Group meeting at GK Savar in November 2002 to help the PHM Secretariat coordinator with planning, strategy, development and steering the evolution of the PHM.
- [The group includes Dr. Ekbal – Regional focal point of India region and Drs. Prem John and Mira Shiva, from the India region, who were PHM - founding core group members].

6. Activities / Initiatives:

a. *Organizational Structure, Clarity and further Evolution* – The PHM Secretariat coordinator and team in consultation with the Steering Group and Support Groups and based on the minutes of the PHM core group and Steering group members (November 2002), spent the first few months clarifying and setting guidelines for the organization structure and evolution of PHM. This has included guidelines for organizational structure.

i. Secretariat
ii. Geographical Circle
iii. Issue based Circle
iv. Role of Focal Points / Facilitators / Contact Points / Convener (See Appendix C)

Communication Strategy:

a. Mass Media / Press Release
b. News brief
c. Website
d. PHM Exchange
e. Charter Translation and distribution
f. Publications and distribution
g. Other communication for campaign / events (See Appendix C)

c. Regional / National Support Activities:

i. Africa Region:

- Following the visit by Maria and Qasem in September 2002 to Arusha (WABA Conference) and the 3 country PHM East Africa solidarity mission by Ravi and Thelma Narayan to Nairobi (Kenya), Kempala (Uganda) and Dar-es-Salam and Arusha (Tanzania) in November 2002, some networking and events have been evolving to enhance the development of activities in the East and Central Africa Region.
- PHM sessions have been added to strategic meetings in the region including a lunchtime discussion at Forum 6 Global Forum for Health Research, at Arusha in November 2002, facilitated by 6 PHM participants of Forum 6 – David Sanders, Zafarullah Chowdhury, Mwajuma S Masaiganah, Sudarshan H., Thelma Narayan and Ravi Narayan (See Networking GFHR also).

Kenya:

- PHM Kenya has announced a formal launch on 23rd August and a Alma Ata Anniversary. Earlier a Primary Health Care Meeting was organized in Nairobi by WCC (May 2003). The SEAM and other conferences are also considering PHM sessions.
- At PHM Geneva meetings a small group of Africa based or Africa linked PHM members met to discuss further networking and mobilization strategy.

Mauritius:

The ex-Health Minister of Mauritius, now PHM contact person in Mauritius, is exploring how PHM – Mauritius circle could host / facilitate a Africa Regional PHM Conference (pre-PHA – II) in November 2003

ii. North American Region:

- At the request of the University of Berkeley, Zafarullah, Ravi and Thelma attended the Annual Public Health Conference on the Theme – 'People's Health in People's Hands: What works? What doesn't and who decides?
- This was followed by a three week (27th February to 16th March 2003) PHM lecture and solidarity tour by the 3 PHM Resource persons that covered the following cities: Berkeley, San Francisco, Polo Alto, Seattle, Portland, New York, Washington DC, UCSF, Stanford, Columbia, Harvard, MIT – Boston and meetings with several NGOs and also the WHO – PAHO Director and Staff.

- The tour was organized by Hesperian Foundation and Doctors for Global Health – the two networks that are focal points for USA and lead to a strengthening of PHM activities in USA.
- A PHM circle, a listserve and 3 issue based circles have now emerged – Trade and Health; Health Care Access; War and Health.
- PHM – US circle has also considered support in fund raising to the WSF – Health Forum in Mumbai, January 2004.

iii. *Europe Region*

UK:

- Ravi held a PHM Dialogue meeting at Health Link – UK during his visit to UK in May 2003 and also lectured at the London School of Hygiene and Tropical Medicine in May 2003, on the People's Health Charter and Beyond.
- Andrew Chetley and the PHM Evaluation Group held the first Evaluation report finalization meeting in London – in May 2003, where there were some representatives from the regions – Africa, Latin America, Europe, South Asia and South East Asia. The PHM Evaluation report will be discussed widely in a few weeks.

Switzerland:

- PHM Geneva group – helped to host / facilitate a PHM Alma Ata Anniversary event in WCC, Geneva, just preceding the World Health Assembly
- A delegation of over 80 PHM members from 30 countries attended the World Health Assembly in Geneva in May 2003. A small representatives group of 6 resource persons had a special meeting with the Dr. Lee (the WHO DG designate) [see separate report and minutes circulation].

Italy:

- Thelma Narayan participated as resource person in PHM –Italy meetings in Bologna, organized by the Italian Circle, when she visited Rome for the Caritas Internationals AIDS Task Force meeting in June 2003.
- AIFO Italy, a key network of PHM – Italy, has awarded PHM the Human Rights Award and a 3 member PHM group from Asia – Africa and Latin America will receive this award at the annual meeting in November 2003.

Russia:

- Petersburg: Alma Ata – 25th anniversary – "Health for All is Necessary and Possible" was held in Petersburg in April 2003.

- Alma Aty: WCC sponsored an Alma Ata conference in Alma Aty, which was reported at the PHM Geneva meting during NGO Forum for Health Session at WHA – May 2003.

Others:

- PHM has been invited for a meeting on Genetics Research in Germany and for the Cochrane Collaboration meeting on Health Equity Culture in Barcelona.

iv. Middle East Region:

- During PHM Geneva meetings a small subgroup of PHM Middle East met to further strengthen Middle Eastern networking. They included representatives of Palestine, Iran and Egypt.
- UPMRC was hoping to organize a July event and involve others from the region but this could not take place due to increased regional tensions.
- Dr. Barzgar (PHM – Iran) facilitated a meeting at WHA Geneva for a small team. This resulted in the Iran government offering to host an Alma Ata anniversary even in Iran in collaboration with PHM in 3rd week of September. This has been actively followed up.
- A 3-4 member PHM International team has been now invited for a four day visit by the Relief Committee of Imam Khomaini – a national NGO working on Disaster and Welfare in the regional PHM activities. Zafarullah and Ravi are expected to go along with Halfdan Mahler, a PHM – Europe member between 9th – 12th August. During this visit apart from discussion with the NGO, there will be visits to some poverty alleviation projects and also dialogue with Ministry of Health and the PHM Iran circle.

v. Asia Region:

Efforts are being made with the help of South Asian and South East Asian Steering group members to enhance PHM networking and mobilization in the region.

- **Asia Social Forum - Hyderabad**: The ASF event in Hyderabad (India) saw a large delegation from Bangladesh and also participation from Sri Lanka and Philippines. They actively participated in the Right to Health Care workshop; the People's Hearing on Environmental Health; the Alma Ata Anniversary workshop; Taking the PHM Forward workshop and the Anti Tobacco Campaign workshop.

- **Sri Lanka**

  The coordinator was invited to be the chief guest at country level meeting in April 2003. He also met the faculty of the medical college; the staff of the Sarvodaya movement and the staff of HAI – AP OFFICE. A medical college get together to discuss the PH Charter and the inauguration of a PHM Resource center in Colombo are being planned for later this year.

- **Philippines**

  A PHM oriented communication and Advocacy workshop is presently going on in Philippines facilitated by HAIN and Health Exchange (UK).

- **The WSF – Mumbai, January 2004:**

  The Health Forum preceding this event and the event itself are strategic opportunities for PHM circles in this region to work together in solidarity and build a stronger Asia Health Movement.

vi. Australia Region:

- The PHM Circle in Australia is organizing a special meeting in September for the Alma Ata anniversary where the government is launching a renewed Primary Health Care policy. The media group and Secretariat are working on some videod messages from other regions for this event.

- MacMillan's in Australia have requested permission from the PHM secretariat to put a link to the website in a chapter on International Health and Development in their school text books, which will invite children to visit the PHM website and answer a set of questions about what they find there.

vii. Latin America:

- Lots of country level meetings and some regional meetings are being organized on PH Charter related issues in Guatemala, Ecuador and Peru. In October, there will be the Che and Espejo Forum in Cuenca and then the International Primary Health Care Forum in Quito.

- The Alma Ata Anniversary film team (Unni and Sathya) have been invited to attend the meetings in October.

- At the WHO – PAHO Dialogue, which Ravi, Thelma and Sarah had with the Regional Director Dr. Mirta Roses – she conveyed her plans to set up a regional level and country level committees to reinvigorate Primary Health Care in the region and she agreed to put a PHM representative in each of these committees.

d. Regional and Global events:

At PHM Geneva meetings of the Steering Group and other participants, a series of regional and global meetings emerged as a run up to the next People's Health Assembly – now scheduled for 3rd – 7th July, 2004 at Porto Alegre – Brazil. These are:

September 2003 – Alma Ata Anniversary meeting in Iran
Islamic Republic of Iran with PHM (Also Middle Eastern pre-PHA meeting)

January 2004 – International Health Forum in Mumbai, preceding WSF – IV, 14th & 15th January.
(Also pre-PHA – II, Asian Regional meeting)

March 2004 – pre-PHA – II Latin America meeting – ALAMES

July 2004 – PHA – II , Porto Alegre

Other four possibilities are also being explored.

November 2003 – Africa Regional Meeting in Mauritius (tentative)

April 2004 – pre-PHA Regional meeting of Australia / Pacific / New Zealand
(Melbourne Health Promotion Conference)

May 2004 – WHA 2004, pre-PHA – II Europe meeting.

October / November 2004 – Post PHA – II. Debriefing meeting in Bangalore, India (what next – after PHA – II)

Unlike last time this time the focus will be on regional events so that the PHA – II is more representative of issues and processes from the regions.

e. Advocacy with WHO

- PHM members at different levels were deeply involved in the WHO – DG election / selection and helped to make it to more transparent and accountable including organizing a public debate with 3 out of 6 candidates.

- A PHM delegation of over 80 members from 30 countries attended the World Health Assembly – May 2003 and participated in the sessions on NGO briefing; Primary Health Care; WHO policy on NGO relation; TRIPS / IPR; Traditional Medicine; Public Private Partnership etc (see detailed report from Geneva).

- A six-member delegation of PHM met Dr. Lee, the WHO – DG Designate and gave him an orientation about PHM; handed him a set of publications; and invited him for PHA – II. He conveyed his decision to make WHO more of a listening organization and increase decentralization and more of focus to country level. He welcomed dialogue with PHM members to keep him and WHO in touch with the realities of Health pf the poor and marginalized in the world. He has now announced a new team, which seems more Primary Health Care oriented. He has also written a letter to PHM Secretariat Coordinator, looking forward to dialogue with PHM in the next few years (see minutes of meeting with DG-designate).

GFHR:

- The Global Forum for Health Research has been in constant dialogue with PHM, since they recognize the potential of the Charter to inspire / provoke researchers around the world to the social – economic – political – cultural determinants of health and health systems, a crucial understanding required to decrease the 10/90 gap in research priorities.

- After the successful participation of a 5 member PHM team at Forum 6 in Arusha, Tanzania in November 2002. (Zafrullah, David Sanders, Mwajuma , Ravi and Thelma). PHM has been invited to have a stronger presence in Forum 7 in Geneva in December 2003. The Research Circle is continuing this dialogue. As of now, David, Maria and Ravi have already been invited as keynote speakers in different plenary and parallel workshops. Other researchers are being identified and included, especially since this year the focus will also be on renewing the Health for All challenge.

f. Networking and Linkages:

- PHM has had a series of dialogues with the Global Equity Guage Alliance (David Sanders and Abhay Shukla) at their request to help them enhance the campaigning and advocacy pillar of their work with the inequity evidence arising out of the gauges.

- A recent meeting in Geneva has resulted in the initiation of a process towards a Global Health Equity Watch report that will be like a Alternative State of World's Health report. A note on the initiative is circulated. PHM will be on the organizational and advisory groups of this initiative. This report will also become the background paper to the People's Health Assembly – II.

    - Links have been established with IBEAN and the recently formed ADAN – People's Alliance for Nutrition – Carmelita (CI – Malaysia) will convene a PHM circle on Food and Nutrition Security and link all these interested in these issues within PHM, with these alliance.

    - Discussions and Dialogue with other networks is going on.

g. New members and linkages

About 5 new members / requests are coming per week to the PHM Secretariat from different parts of the world via the website or PHM Exchange. The communication officer keeps in touch with them, linking them to the PHM process at country region and sending them relevant information and communications.

h. Various other processes are going on

- The Alma Ata Anniversary film – due to delay in funding this has not yet taken off, but we hope the new time schedule from July 2003 to final release pre or at PHA – II will take place.
- Fund Raising: This is an ongoing concern and activity. A contribution of short event / initiative oriented campaigning for small grants has been quite successful.

- A log frame exercise and 3-year plan to send to some larger donors for core grant is in the process of being evolved.
- Building up PHM Resource Centers at country / regional level.
- Advocacy with PH Charter at all levels beginning with translations and distribution (presently 40 translations have been completed)

i. Finances:

A large networking operation such as PHM including the coordinating secretariat needs a secure financial support. A process towards this is being gradually evolved by a six member funding group consisting of Qasem, Prem, Bala, Maria, Olle, Andy, who support the coordinator in this crucial aspect.

- A one year budget estimate, January 2003 – December 2003, was prepared after ASF in Bangalore with the help of Qasem, Prem and Olle.

- The funds available with PHM as of 1st January 2003 consisted of a small diminishing balance left over from PHA – II and which had been used since January 2001 for PHA / PHM activities.

- Funds have been now raised through a variety of sources as small grants for specific initiatives / events.

- The funds are managed as follows: Andy Rutherford (One World Action – UK) operates at PHM – OWA account in UK, which receives all the grants. He then disburses the amount on the authorization of the coordinator for different events and to different PHM people and regions. A small grant is sent to the secretariat primarily disbursed in India. (A detailed statement is available of position till 1st July 2003.)

- A 3-year project proposal which will include this first year proposal will now be drawn up with the help of Bala, Prem, Qasem and others by end or July 2003. For this purpose, a detailed planning and strategy evolving communication in three parts with 5 appendices has been circulated to all steering group members to get regional information, needs, events, responses. A log frame exercise is being evolved from all these replies. This will include estimates for larger events like Iran meeting; Mumbai meeting (WSF) and Porto Alegre (PHA – II). A concerted fund raising campaign will be evolved with an effort to broad base the support rather than focusing on a few large grants.

j. In Conclusion

Finally the secretariat has been trying against some odds and constraints to build up a collective decision making process at global and regional level and even at country level by linking, orienting, counselling, building communication channels and strengthening communication strategies - list serves, websites etc. The whole process is to strengthen the base and collectivity of the movement.

The challenge is four fold:

a. To ensure that the process of PHM mobilization is inclusive (not controlled by a few people or NGOs, but becomes a broader civil society / people's movement) in every country and region.

b. To ensure that there are processes in countries of dialogue and communication collective action and the movement is not only event driven.
c. To get ongoing PHM – members individuals, networks and campaigning groups to be constantly aware that PHM is not a separate /side / episodic activity but to recognize that all they are doing already in PHM and sharing it and labeling it as such is important.
d. To encourage that ultimately people's voices, 'testimonies' collective actions get precedence over expert and ideological prescriptions, which are often top down and sometimes unrelated to grassroots experience.

This is an ongoing challenge and needs the commitment of many more PHM members, to give more time to the process of movement building.

Bangalore
25th July 2003

Ravi Narayan
Coordinator
PHM Secretariat (Global)

"Thirty months after PHA 2000, our challenge remains the same – though more urgent. It still calls for the same main actions and makes the same demands made in our People's Charter for Health as summarized therein. But for this challenge to materialize in concrete, concerted actions, more of each of you need to get involved. (It is therefore, not sufficient for this short document to rehash what needs to be done). Each of our members needs to recommit her / himself: We need more of your time! Perhaps the moment has come to abandon some of the irrelevant work we all get involved in. We can no longer afford missing the forest by focusing on the trees….."

- Claudio, PHM 2002

INDEX OF PHM SECRETARIAT (GLOBAL) HANDOUTS

1. Website – PHM who's who list
2. PHM Regional / Country Listing
3. PHM Evolving Organizational Structure
4. PHM Report from London and Geneva

5a. NGO briefing – WHA

5b. PHM – WHA 2003 Statements and Minutes

5c. PHM Meeting with Dr. Lee, WHO – DG Designate

5d. PHM – WHA 2003 Report (by Mira Shiva)

6a. Communication I – Planning and Strategy

6b. Communication II – Planning and Strategy

6c. Communication III – Planning and Strategy

7. PHM Iran Meeting Framework
8. PHM – WSF Health Forum and PHA – II
9. PHM Global Health Equity Watch Report (GEGA)
10. PHM Alma Ata Position Paper
11. News Brief Framework
12. PHM Communication Strategy - Draft

APPENDIX A

How to Contact the People's Health Movement

Secretariat

Postal Address:

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Steering Committee

The Steering Committee includes representatives from 8 founding networks / organizations and involved in organizing the first People's Health Assembly and establishing the People's Health Movement and 8 regional facilitators. In 5 more regions the process of electing the facilitators is ongoing

Qasem Chowdhury	**Outgoing Coordinator**	gksavar@citechco.net
Founding Networks / Organizations		
Prem John	Asian Community Health Action Network (ACHAN)	prem_john@vsnl.net
Carmelita Canila	Consumers International (CI)	carmelita@ciroap.org
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International Advisory Body

The Steering Committee and the Secretariat are supported by a wider group of individuals and organizations around the world. This includes a growing number of Country contacts, a Secretariat Support Circle, and a growing number of issue-based Working circles.

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Working Circles

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PHA-Exchange - Mailing List Discussion
join | prior postings

The People's Health Assembly is an international grassroots network of organisations and individuals that came together in 2000 to re-ignite the call for Health for All Now! 1500 participants from 94 countries came to the inaugural assembly in Bangladesh in December 2000.

The list server is the crucial networking system set up to stay in touch to consolidate our work worldwide. We will exchange experiences, share educational materials, do solidarity work, coordinate our positions for international meetings and for lobbying. In this day and age, the list is indispensable for our work as committed change agents.

How to **join the mailing list discussion** and Instruction on how to join the list are given at:
http://lists.kabissa.org/mailman/listinfo/pha-exchange

To **see the collection of prior postings** to the list, visit the PHA-Exchange Archives
http://lists.kabissa.org/lists/archives/public/pha-exchange/

APPENDIX B

Countries represented in PHA 2000	Country contact points established after PHA 2000	Countries not represented
ASIA – SOUTH :		
BANGLADESH, NEPAL, PAKISTAN, SRILANKA		(MALDIVES) (BHUTAN)
INDIA WITH 19 STATES		
ANDHRA PRADESH, BIHAR, CHHATTISGARH, DELHI, GUJARAT, HARYANA, HIMACHAL PRADESH, KARNATAKA, KERALA, MADHYA PRADESH, MAHARASHTRA,ORRISA, PUNJAB, RAJASTHAN, TAMILNADU, TRIPURA, UTTAR PRADESH, WEST BENGAL,	JHARKAND	ARUNACHAL PRADESH, ASSAM, GOA, JAMMU AND KASHMIR, MANIPUR, MEGHALAYA, MIZORAM, NAGALAND, SIKKIM, UTTARANCHAL
CHINA		
CHINA		
ASIA – SOUTH EAST:		
INDONESIA, JAPAN, KOREA, MALAYSIA, MYANMAR, PHILIPPINES, SINGAPORE, THAILAND, VIETNAM, CAMBODIA		(HONG KONG), (LAOS), (BRUNEI), (TAIWAN)
AFRICA – SOUTH		
MOZAMBIQUE, SOUTH AFRICA, ZAMBIA, ZIMBABWE, MAURITIUS		(ANGOLA) (NAMIBIA), (BOTSWANA), (MADAGASCAR) , (MALAVI), (LESOTHO) (SWAZILAND)

Countries represented in PHA 2000	Country contact points established after PHA 2000	Countries not represented
AFRICA – EAST AND CENTRAL		
KENYA, TANZANIA, UGANDA, SEYCHELLES	CONGO	(ZAIRE), (ETHIOPIA) (SOMALIA) (CENTRAL AFRICAN REPUBLIC) (RWANDA), (BURUNDI),
AFRICA – WEST		
CAMEROON, GHANA, MALI, SENEGAL	TOGO	(NIGERIA), (MAURTITANIA), (NIGER) (CHAD) (SUDAN), (IVORY COAST), (GABON), (GAMBIA), (BENIN), (BURKINA), (GUINEA), (LIBERIA), (SIERRA LEONE)
MIDDLE EAST AND NORTH AFRICA		
EGYPT, IRAN, IRAQ, JORDAN, LEBANON, MOROCCO, PALESTINE, SUDAN, TUNISIA, ARMENIA, TURKEY, AZERBANJAN		(LIBYA), (ALGERIA), (ERITREA) , (SYRIA), (SAUDI ARABIA), (QATAR), (UAE), (KUWAIT, (TURKMENISTAN), (AFGHANISTAN), (ISRAEL), (KAZAKSTAN), (UZBEKISTAN), (KYRGYZSTAN), (TAJIKSTAN), (BAHRAIN), (YEMEN), (OMAN)
PHM – EUROPE		
BELGIUM, DENMARK, FINLAND, FRANCE, GERMANY, GREECE, ITALY, NETHERLANDS, NORWAY, RUSSIA, SWEDEN, SWITZERLAND, UNITED KINGDOM, TURKEY, UKRAINE,		(ICELAND), (IRELAND), (PORTUGAL), (SPAIN), (ANDORRA), (MONACO), (LUXEMBURG), (AUSTRIA), (LIECHTENSTEIN), (SAN MARINO), (VATICAN CITY), (MALTA), (POLAND), (SLOVAKIA), (SLOVENIA), (CROATIA), (YUGOSLAVIA), (BOSNIA –

		HERZEGOVINA), (MACEDONIA), (BULGARIA), (ROMANIA), (MOLDOVA), (CZECH REPUBLIC), (HUNGARY), (LITHUANIA), (LATVIA), (BELARUS), (ALBANIA), (ESTONIA)
NORTH AMERICA		
CANADA, UNITED STATES OF AMERICA		
CENTRAL AMERICA, MEXICO AND THE CARIBBEAN		
CUBA, DOMINICAN REP, EL SAL VA DOR, GUATEMALA, JAMAICA, MEXICO, NICARAGUA, COSTA RICA		(PANAMA), (HONDURAS), (BELIZE) (HAITI), (BAHAMAS), (TRINIDAD AND TOBAGO), (ANTIGUA), (DOMINICA), (BARBADOS), (GRENEDA), (ST. KITTS – NEVIS), (ST. (VINCENT AND THE GRENADINES)
SOUTH AMERICA		
ARGENTINA, BRAZIL, CHILE, EQUADOR, PERU, URUGUAY, COLUMBIA,		(VENEZUELA), (GUYANA), (SURINAM) (FR. GUYANA), (BOLIVIA), (PARAGUAY)
AUSTRALIA AND PACIFIC		
AUSTRALIA, FIJI, NEW ZEALAND, PALAU, SAMOA		(MARSHALL ISLANDS), (FED. STATES OF MICRO NESIA), (PAPUA NEW GUINEA), (NAURU), (KIRIBATI), (JONOA), (SOLOMAN ISLANDS), (TUVALU), (VANUATU), (NORTHERN MARIANES)

APPENDIX – C

PEOPLE'S HEALTH MOVEMENT – ORGANISATIONAL STRUCTURE AND FRAMEWORK – SOME GUIDELINES

(To be put on the website. Any suggestions / corrections?)

A. BACKGROUND

1. Two years since the historic People's Health Assembly at the Gonoshasthaya Kendra (GK) campus at Savar (Bangladesh) in December 2000, the People's Health Movement has evolved as a dynamic and responsive voice of the voiceless. Further, it has put a challenge at the academic and intellectual level by challenging anti-health and anti-poor policies at the International level.

2. The first Core Group meeting that was held at the GK campus in the last week of November 2001, brought back nostalgic memories and the collective energy that was demonstrated at the venue of the PHA 2000. This core group that had facilitated the global process and the secretariat of the People's Health Movement reflected on the road the movement has traveled since PHA 2000 and evolved some strategies to move forward.

3. People's Health Movement's Core Group meeting at Savar (GK: 20th-22nd Nov 2002) reviewed and endorsed the strategies once again and evolved a plan for synergic and decentralized action towards this new framework. The following are the important guidelines that emerged about the process, organisation structure and working principles of people's health movement and its various circles.

B. STRUCTURE OF PHM

- PHM should be an enabling process and decentralised actions should be the building block. Any structure for PHM should be based on this foundation and should ensure synergy.
- The challenge for a growing movement is to ensure how we link and relate with the existing structures of other networks and movements to ensure synergy
- There should not be any centralized decision making process.
- Circles and other constituents of the movement should be encouraged to take decisions and move on and the secretariat should facilitate the pace and spirit with no bureaucracy
- Facilitation and empowerment should be the objective of geographic and working regional circles
- The Structure of the PHM will be intersecting circles of 2 types

    - Geographical circles

        (a) Regional circle (13 Regions, see table)
        (b) National circle (92 +)

(c) Local circle (These could be at village / town / city / district / state level – depending on situation)

Each region will consist of a coalition of national circles. National circles depending on the size of the country would consist of state circles and state circles could consist of district circles and so on.

- Issue based working circles (membership of this would be drawn from different geographical areas on a purely voluntary basis

- Secretariat

  - Regions will host the secretariat from time to time
  - The secretariat will coordinate, facilitate the working together of all the geographical and issue based circles

- Secretarial support group

  - Steering group

    Earlier called the Core group, this 23 member group will steer the decision making process of the movement, particularly the international and collective initiatives

  - Funding group

    Helps in the decision making process of funding, finances etc.,

  - Communication and media group
    Helps and supports the secretariat on all the communication and media related work

GEOGRAPHICAL CIRCLES

General working principles:

- 13 geographical circles have been formed. Generally a network organization would be the host of a geographical circle.

- Identification of groups / networks in regions is important (not only individuals or NGO's) to provide extra support to consolidate and facilitate PHM activities

- Circles should be inclusive and help to reach out to more people who are working on issues that are important to PHM. This will be one way to expand the reach and domain of the PHM as a movement

- The evolution of geographical circles at country and state levels is a gradual process

- Each geographical circle will have a facilitator elected from the region, country or state. S/he must have the following capacities to enable the movement building process

- People/ organizations / networks need to be constantly identified by the Secretariat and the steering group to facilitate activities in locations where PHM doesn't have any presence. The constituting bodies of PHM, who may have their presence or links in such places could take the initial responsibility to identify facilitators in such places. Eg: IPHC in Americas, Australia and ACHAN in South East Asia, WGNRR in East Africa, HAI, CI and TWN in other regions. Focal points from neighbouring regions could help the PHM secretariat in this process

Responsibilities of Facilitators and Link Persons

- **Facilitator**

  - Should be representative – of a group / network in the region/ country
  - Must have an understanding of the ground reality of the region / country and policies
  - Must have skills of motivation, networking, and capacities to communicate, accounting, computer etc.,
  - Must be responsible to a parental organization/ network for support
  - Must be inclusive and able to dialogue with a wide cross section of networks and individuals

- **Link person**

  The initial selected/ nominated contact in a geographical area- country or region will be called a link person. When the group increases in size and representation then the facilitator should be elected democratically for a period of 1-2 years

ISSUE CIRCLES

- An issue circle will facilitate the initiation of dialogue on the specialized issues
- Each issue circle will have a Convenor, who will facilitate the sharing, perspective building and communication process.
- S/he will strengthen the work done by individual members of the circle
- It will help PHM understand such issues better and at times take positions and provide input to the PHM process on

specific issues and give suggestions about who could represent PHM when PHM gets invited for events on these specific issues
- S/he will be responsible mainly to the circle members and to the steering committee and PHM secretariat

- **Link person**
  The initial selected/ nominated contact in a geographical area- country or region. When the group increases in size and representation then the convenor will be elected democratically for a period of 1-2 years. Convenorship could rotate within the group.

C. SECRETARIAT

- The Secretariat will be hosted by different regions in rotation
- Some of the activities will be retained at the previous secretariat
- 2-3 years will be the period for the secretariat to be in one place
- Use of a letterhead renamed as People's Health Movement reflecting steering group of networks will be promoted
- The secretariat will be supported by a steering group in the decision making process
- Secretarial support group will be evolved for communications and publications, media, PHM exchange, funding etc.,

- **Functions**
  - Facilitation and empowerment of PHM vision
  - External / Internal communication in PHM between member and circles
  - Management of collective initiatives and events
  - To designate planning, monitoring and evaluation
  - Fund raising and financial management
  - Working with members, donors, facilitators, contact points etc.,
- **Minimum needs for smooth functioning of the Secretariat**
  - Full time Secretariat coordinator (on deputation to PHM secretariat from hosting organisation)

- A communication officer (website) capable of dealing with communication challenges

- A technical officer to help the coordinator (could be short term volunteers or short term linkage)

- A person for accounts secretarial support

- Some office infrastructure, computer, telephone, fax, basic library, office space drawn from hosting organization and supported by PHM budget

    - **Secretarial support group**

        - **Steering committee**

            - A steering committee consisting of the 8 networks and the 13 regional centers along with the incoming and outgoing coordinators help in collective decision making. It will meet at least once a year to take stalk of the evolution and challenges of the movement and plan responses and strategies

            - It will also constantly identify regional / international events that could be used as strategic opportunities for both PHM participation and smaller group steering committee meetings and dialogue

            - A steering committee discussion group (yahoo group) will be established to help the secretariat keep all members involved and informed in all the key decisions

        - **Funding group**

            - A 6 member funding group assists the secretariat in financial and funding matters helping to evolve the project proposals, budget, logical frame and identifying and dialoguing with potential partners on behalf of PHM

        - **Communications and media circle**

            - Will facilitate both internal and external communication and thereby contributing to the expansion of the decentralized movement.

            - Website and related communication activities and through this increase the visibility of the movement

            - E-mail communication with usage of PHM signatures

            - Issue of timely press releases and publication of the same

- Devising methods to overcome the digital divide
- Launch of campaigns (for eg. Million signature campaign)
- Regular press releases on health issues of global concern

- **Publications / PHM resource centre**
  - The GK Savar centre, which hosted the secretariat for the first two years will continue as a PHM resource centre
  - It will bring out a Newsbrief and related newsletters to highlight the activities during a specified period (keeping the digital divide in sight)
  - It will publish the policy/ background papers and in coordination with organizations / individuals from the regions
  - A small editorial group would support this activity.
  - Sometimes a small additional group would be formed for a specific publication
  - The centre will also keep track of all the publications, handouts, educational and promotional materials that evolved in the PHM –Globally, regionally and at country level (Archives)

- **Secretariat – Criteria for selection in a region**
  - Willingness to host the secretariat by the organisation and endorsement by the regional circle
  - Must have skills in communication, management, finances, project implementation and reporting
  - Must be inclusive and have skills in networking and advocacy
  - Must be committed to the PHM vision and the People's Charter for Health

Source Minutes of PHM Core group [illegible] Nov 2 [illegible] and discussions in PHM [illegible]

COMMUNICATION – VII **30 May, 2003**

Communication from PHM Secretariat

Reporting from London and Geneva, May 2003

In the last two weeks (from 9th May till 28th May 2003), a series of important and significant initiatives have taken place in the context of the evolution of PHM and this is a brief report of the key events, the decisions and the relevant issues for the PHM Steering group as well as all PHM members. A more detailed report with supporting documentation will be circulated as a consolidated file as well as a series of communications on the PHM Exchange in the next few weeks.

1. EVALUATION OF PHM:

- A detailed evaluation of the PHA process before and during the Assembly and of the evolving PHM process after the assembly has just been concluded by a small evaluation team led by Andrew Chetley (Exchange – UK) and three other participatory research consultants – Roberto (Peru), Mwajuma (Tanzania) and Cecilia (Uruguay).

- The main findings of the evaluation were analyzed and discussed at a three day Review meeting in London (9th to 12th May 2003), where a few PHM participants representing different regions of the world helped to contextualise the findings. The review was planned very well and included sessions on:

a. Reflections on pre-PHA planning – how did it emerge? What worked well? What was difficult? What was happening locally (in Latin America, in Asia, in Africa, in Europe, elsewhere)?
b. Reflections on the PHA –what was significant? What worked well? What was less good? What would have made it better? Was anything missing?
c. Reflections on the post-PHA period and the development of the PHM – what are some of the significant achievements? What has not worked? What needs to be improved? How strong are the roots of the movement? (What's happening in local areas)
d. What others are saying?
e. What are the main conclusions we can see emerging? What are the lessons that could be most valuable in strengthening the work of the PHM in the future? What are the messages that we might want to communicate to a wider audience?
f. Would you do it again? What would you change? How would you do it differently? What would you keep and build upon? Are there lesions for the proposed assembly in 2004?
g. Recommendations and unresolved issues / questions.

- Over all, the 'evaluation' confirmed that the PHA had been a personally endorsing, inspiring and meaningful experience for all those who participated in the 5 day meeting at GK Savar in December 2000. Those who came linked to group or collective processes of mobilizations from different countries and regions, could build on the inspiration 'of the global solidarity' evident at the Assembly and take the process forward in their own countries after the Assembly.

- A large number of initiatives have taken place all over the world and the main challenges for the evolving post PHA, movement is to establish interactive communications and an organizational framework that enhances creativity and collectivity without too much centralization or limiting structures

- There were many lessons to be learnt as well for future assemblies and for the ongoing communication and organizational challenges for the movement (A more detailed report will be soon available on the PHM Exchange and the website).

2. PHM GENEVA 2003:THE ALMA ATA ANNIVERSARY DIALOGUE

- Over 80 PHM delegates from 30 countries gathered in Geneva to attend the PHM Geneva 2003 event, an Alma Ata Anniversary dialogue on 16th – 18th May at the World Council of Churches, facilitated by our active PHM Geneva group. The four major thematic sessions were:

  a. Primary Health Care and the Health for All campaigns and initiatives from all over the world.
  b. Access to Affordable and Essential Drugs.
  c. War, conflicts and Disasters – Health and humanitarian challenges – which included reports from Iraq, Palestine, Philippines, Congo, Sri Lanka and other conflict zones.
  d. Global health and the diseases of Poverty, TB, HIV, Malaria.
  e. A WEMOS facilitated workshop on the effects of GATS agreement on access to Health Care and effects of WTO agreement on food and nutrition.

- The delegates included the following:

  Fran Baum (Australia); Zafarullah, Nouman, Momtaz, Taznihar, Babul, Abdul Zabbar, Zubair, Karnal Uddin Ahmed and Mohibubul Haque (Bangladesh); Armando (Brazil); Rosalie Bertell (Canada); Patricia Nickson (Congo); Hani Serag (Egypt); Arturo Quizhpe (Ecuador); Margarite Posada (El Salvador); Gopal Dabde, Barbara, Schimmer and Gaby Hetler (Germany); Hugo Icu Peren (Guatemala); Sundararaman, Sudha, Amit, Mira Shiva, Prem and Hari John and Johny Oomen (India); Mohd. Ali Barzgar (Iran); Sunil, Savatore Anna and Maria Teresa (Italy); Samuel Ochieng, Samuel Muwenda and Eva Ombaka (Kenya); Carmelita Canila (Malaysia); Natalia, Cebotarenco (Moldavia); Marjan, Ellen, Patrick, Melina, Jose, Preeti, Marianne, Annelies, Anke, Nina, Leontien (Netherlands); Maria (Nicaragua); Ghassan (Palestine); Edelinda (Philippines); Bala, Niranjan, Paranie, Thiru (Sri Lanka); David Sanders (South Africa); Halfdan, Nance, Jean, Allison, David Woodward, Eugenio, Andres, Monika, Manoj, Eric Ram, Anne Lindsay, Christine, Manjith, Jourdan Genevieve, Michelle and others (Switzerland and some France); Mwajuma (Tanzania); Pam, Mike, Andrew Chetley, David McCoy (UK); Denise Zwahlen, Sarah, Eric, Charlotte (USA); Cecilia Muxi (Uruguay); Lexi Bambas (Zambia), Ravi Narayan (PHM Secretariat), Unnikrishnan (India) and Satya Sivaraman (Thailand) – the PHM Media team.

- Some WHO team members also attended some of the session. They included Dra Mirta Roses (Director of PAHO); Dr. Asamoah Baaha (Drugs and Vaccine section); German Velasquez (Consultant, Essential Drugs Unit); Eva Wallstam (Director, Civil Society Initiative) and Josephine Matsumoto (Ext. Relations Officer).

3. PHM STEERING GROUP AND STRATEGY MEETINGS

Since the over 80 delegates included many of the steering group members representing the 8 funding networks and the evolving 13 regions of the world, a series of meetings were held from 16th to 18th May in between and after the PHM Geneva 2003 dialogue to evolve strategies and initiatives for the year. The key decisions and suggestions were as follows (a more detailed minutes will be available soon):

- The organizational structure and framework evolved during the steering group meeting at GK Savar (November 2002) was discussed and circulated. These included structure of PHM – local, national, regional geographical circles; issues circles; secretariat, Steering group; general working principles of all these; responsibilities of focal points and convenors; secretariat criteria; functions and support group.
- The list of 92 countries (which included 17 state teams from India) classified by global regions and list of over 100 countries still to be reached was circulated to encourage PHM members to help mobilize contact persons from all over the world.
- Andrew Chetley reported the overview and key findings of the PHM Evaluation; Unni presented an update on the Million signature campaign; Maria,Armando, Amit and Unni reported from the World Social Forum and Health Forum (Porto Alegre, January 2003).
- The News brief 9 focusing on shift of secretariat; Asia Social Forum; the November 2002 Steering Committee decisions; the Sri Lanka HAI-AP meeting; the Human Rights Award for PHM by AIFO, Italy; the media releases from the PHM media team and other news items was distributed at Geneva. The next News brief 10 will focus on the World Social Forum, January 2003; and the PHM regional support tours to East Africa and the USA regions and the PHM Geneva events.
- A position paper facilitated by David Sanders on Primary Health Care in the context of the Alma Ata Anniversary initiatives was circulated to many members for final comment and suggestions. This will be ready for distribution by PHM, as a position paper by end of May.
- Melina presented the details of the launch of the Women's Access to Health Campaign at the PHM Geneva dialogue and Lexi Bambas and David McCoy presented the highlights of the PHM – GEGA Joint initiative in evolving an 'alternative state of World's Health Report' as an evolving process to monitor global determinants of inequity and ill health with a focus on international health players and global initiatives. These were endorsed by the PHM delegates.
- In lieu of announcement of the next People's Health Assembly in Porto Alegre (Brazil) in July 2004 and the potential of organizing another Health

Forum before the World Social Forum in Mumbai (January 2004), a four member sub committee consisting of Maria, Amit, Armando and Mwajuma met and evolved a framework for these events and the process of evolution and planning. This was presented to the group. A series of smaller follow up discussions were held during the whole PHM Geneva phase based on these suggestions and a more detailed schedule of potential events is outlined in section 5 (see later)

4. THE PHM PRESENCE IN THE WORLD HEALTH ASSEMBLY 2003

As one of the largest delegations to the WHA this year (over 80 delegates from nearly 30 countries) the PHM contingent made its presence felt and its enthusiastic and critical interventions were much appreciated. The PHM had grown in strength as a delegation – from 6 in WHA 2001; 35 in WHA- 2002 and now 80+ this year. The key initiatives were as follows:

- The presence of the PHM delegation at WHA was facilitated by PHM partners which included World Council of Churches (Churches Action for Health); Consumer International; Infact; and Save the Children, UK. Our thanks for their solidarity.
- The PHM delegates were given an orientation to the process of advocacy in the World Health Assembly, in two orientation sessions, which included a role-play. These sessions were facilitated by Andrew, Cecilia and Carmelita and this greatly enhanced the PHM interactions. Carmelita was appointed the Advocacy coordinator and issues, events, responsibilities were divided among the group and small groups of PHM volunteers were seen actively in action throughout the 10 days.

- PHM participated in 6 NGO- related sessions in WHA which included:

  a. Session on **Public- Private Health Care** on 19th May organized by WCC and PHM . David Woodward (Geneva), Sundararaman (India) and Samuel Ochieng (Kenya) were the panelists.
  b. The NGO Forum for Health session on 20th May on the theme: **The Primary Health Care Movement after 25 years of Alma Ata: A Civil Society perspective.**

  The panelists included Maria (Nicaragua), Delen (Philippines), Eva and Samuel (Kenya), Prem John (India), Nouman (Bangladesh), Natalia (Alma Aty), Dr. Barzgar (Iran), Johny Oomen (India), Patricia Nickon (Congo).

  Dr. Raphael Bengoa of WHO also shared some of the key messages on Primary Health Care from the recently completed WHO review which provoked much discussion.

  c. A session on **'Medicine Prices – a new approach to Measurement'** was organized by Health Action International and WHO on 20th May, evening which was very well attended.
  d. On 21st May, there was an open seminar on National Capacity building for Health promotion: cooperation and partnership among governments, NGOs

and WHO in overcoming risks to health: This was organized by the NGO Adhoc Advisory Group on Health promotion.

e. On 21st May, there was a lunch time discussion on " **Traditional Medicine and Spiritual dimensions in Health**" organized by the NGO Forum for Health and the NGO Committee on Spirituality, values and Global concerns of CONGO in relationship with UN.

   Ravi (PHM Secretariat) and Zafarulah (Bangladesh) made short presentation and the animated discussion was supported by Prem and Hari John, Bala, Mira, and others of PHM.

f. On 22nd May, Save the Childern, UK in collaboration with a WHO Strategy unit organized a session on New Developments in pro-poor health policy which was also well attended.

- The participation of PHM delegates in the WHO – process especially on the agenda items of committee A was as follows.

  a. The PHM delegates attended the NGO briefing by WHO on 19th May in full strength. The four presentations on Policy for relations with NGOs (Eva Wallstam); the Framework Convention for Tobacco Control (Derek Yach); WHO and Millenium Development Goals (Andrew Cassels); Intellectual Property rights, innovations and public health (Jonathan Quick) were received with great enthusiasm and at least 5-6 PHM delegates responded to each presentation, establishing the active, enthusiastic and critical presence of PHM at WHA at the beginning itself.
  b. PHM delegates focused on Committee A agenda and attended the sessions on

     - Primary Health Care
     - Framework Convention on Tobacco Consortium
     - WHO contribution to MDGS
     - Strategy for Child and adolescent Health and Development
     - WHO and HIV / AIDS
     - Intellectual Property Rights, innovation and Public Health
     - Traditional Medicine
     - Strengthening Health Systems in developing countries
     - Policy for relations with NGOs
     - Joint FAO/WHO evaluation of Codex Alimentarius Communication.

  c. PHM made NGO statements in committee A on the following issues.

     - Primary Health Care (Churches Action for Health and People's Health Movement)

- Concerns and suggestions on Policy for relations between WHO and non-governmental organizations from a public (in collaboration with CI, IBFAN and others)
- Joint NGO response to US proposal on IPRs, Innovation and Public Health (in collaboration with MSF; Health GAP; HAI; ACT UP Paris; Oxfam, Treatment Action Campaign; Canadian HIV / AIDS legal network; stop AIDS now!; stop AIDS alliance)
- A draft PHM response to the Report of the Director General WHO – 1998-2003.
- A note on IPR.

d. PHM Media team facilitated 7 press releases on the following themes during the WHA:

War on Health is killing the dream of Health for All (16th May); Tobacco today, Arms Trade tomorrow – PHM demands WHO target the World's largest killer industry (20th May); Revive the spirit of Alma Ata - More Action, Less words please (21st May); Hyper on SARS, Silent on WARS – will the new WHO DG break the silence (22nd May); Stop attacks on Palestine Medical Facilities! WHO is there in an emergency (22nd May); Towards the next People's Health Assembly, Porto Alegre – July 2004 (26th May).

On 20th May, PHM also joined IPHC, Equinet, Medact, WEMOS, Save the Children and World Development Movement in a joint Press statement entitled "Health groups warn World Health Assembly, on new WTO threat to Public Health.

e. Small PHM teams also participated in a few Press Conferences on 16th May, 20th May, and on Wars, Conflict and health; and Primary Health Care and other issues of concern for PHM.

f. The highlight of the WHA interaction this year was the dialogue with the new WHO-DG Dr. Lee, who met a 5 member PHM team on Thursday 22nd May and listened to PHM concerns and expectations of WHO. The team included Ravi (Coordinator, PHM Global Secretariat); Maria (representing Latin America); Mwajuma (representing Afrcia); Zafarullah (representing Asia); and Ghassan (representing Middle East). The PHM welcomed the expressed thrusts of the new DG including Primary Health Care; Decentralization and focus on country offices and action; WHO as a listening organization, and not only a guiding one. We shared our willingness to work with the new DG as critical allies and strengthening civil society voices in International Health decision-making. We also invited him for the next PHA – 2 in July 2004 at Porto Alegre (Brazil). The team also presented him with a set of PHM publications.

5. THE SECOND PEOPLE'S HEALTH ASSEMBLY

- The II Peoples Health Assembly (also to be called the first World Health Social Forum) will be held in Porto Alegre Brazil from 3rd to 7th of July 2004.

- The assembly will bring together living visions / testimonies from the people and analytical perspectives on the global and local health situation by specialists and scholars from all over the world committed to the Movement. It will generate a solid basis for action in a political content for the next four years 2004-2005.
- It will build on a process of communication and empowerment, reinforcing the regional organization of the PHM and widening the coalition of organizations associated with it.
- It will focus on the Struggle for the Universal and Equitable Right to Health and the Globalization of solidarity; **Health as an essential human need**, a right of citizenship, a duty of the state and the responsibility of the society and a public good.
- Some of the key themes will be Health as Human right; and the legal expressions of it. Trade issues and health; Environmental destruction and Health; Militarism, conflicts and Health; Right to access; Science and technology and its advancements; Equity; State and Health system reforms and the right to health and PHC and health promotion in the context; Human resources for universal health; Economics of universal health systems; Poverty and Health; Women and Childern's rights. Other themes would include Food Security; Water and sanitation, HIV/AIDS; Access to drugs; drugs and substance addiction and mental health as social / economic issue; Mother and child care; endemic diseases; injuries and violence; chronic and degenerative diseases.
- A core international committee consisting of the sub group already formed (Maria, Amit, Armando and Mwajuma) and others who volunteer from the regions will be formed to work on the mobilization process, the funding and finances, the contents and programmes, the logistics and the ongoing monitoring and evaluation.
- There will be at least three pre-Assembly events which will also become focused as Regional activities in preparation for the PHA – II.

  a. ***September 2003***: The Alma Ata Anniversary Meeting hosted by the Islamic Republic of Iran in collaboration with the People's Health Movement in the second half of September 2003. This will also be a regional preparatory meeting focusing on the Middle East and Africa regions. Support from EMRO / SEARO is being explored. (Dates yet to be confirmed).
  b. ***January 2004***: A two day health forum on 14th / 15th January will be organized preceding the next World Social Forum to be hosted in Mumbai, from 16th to 21st January. This forum also entitled the III International Forum for Defense of People's Health will be focused as a regional preparatory meeting for Asia – both South and South East.
  c. ***March 2004***: The ALAMES congress in Peru in March 2003 could become a regional preparatory meeting for the America.

  All these meetings will have to be planned in a participatory way with democratic representations and process in countries and the region and the numbers at events will also depend realistically on the funds / other resources mobilized in the regions and internationally.

- [The secretariat will initiate action to facilitate this process at a more rapid and sustainable pace. A separate communication follows on this important development].

6. BUILDING COALITIONS AND LINKAGES:

The PHM Geneva events were a strategic opportunity to build coalitions and linkages with a wide variety of networks and global initiatives relevant to people's health concerns. The key linkages established were:

a. **The Global Forum for Health Research:** A dialogue was held with GFHR during the Geneva meeting, for PHM participation in Forum 7 in Geneva from 2-5 December 2002. The PHM inputs by Zafarullah, David, Thelma and Ravi at Forum 6 in Arusha, Tanzania were very much appreciated. Areas and sessions where PHM participants could make significant 'evidence based' inputs were identified. These included the plenary on Poverty and Health Research; and the Parallel sessions on Primary Health Care, Nutrition, Poverty and the life cycle; behavioral and community based interventions and social, economic, cultural and political determinants; Gender and Mental Health. David Sanders, Convener of Research circle and Ravi (PHM Secretariat) will follow up on this.

b. **A circle on Food and Nutrition issues** focusing on right to food; Nutrition security;Junk foods; sugar issue etc would be facilitated by joining IBFAN and other networks like APPAN, which were set up by the SCM – Nutrition meeting in Chennai in March 2003. Carmelita of CI-ROAP would be the Convener and contact person. PHM plans to start an advocacy circle with UNICEF on the Macdonald linkage and other issues would be merged with this circle evolving in a much broader context.

c. **Anti Tobacco Circle:** While many PHM members have also been involved with the Tobacco issue and the FCTC process and the Civil Society involvement in support of it, it was felt that IN FACT and other anti-tobacco groups should be contacted and a circle to learn from the experiences of the FCTC lobby process as well as monitoring the post FCTC process at country level should be encouraged. It would also be important to involve the anti-tobacco networks to organize workshops on their experiences at WSF and PHA – II next year. A volunteer convener would be identified for this circle.

d. **Public-Private partnership Circle:** In the context of the WEMOS supported research process on Public – Private partnerships and the presence of potential county level partners in Bolivia, India and Kenya, it was felt that Jose Utrera could be requested to be the contact point for a circle on this issue and that links with Judith Richter and other networks working on he Global determinants of these partnerships should be established.

e. **PHM – GEGA partnership on Global Equity determinants**: The links with GEGA, MEDACT – UK and others in the collaborative project to look at Global determinants of Equity and to evolve an evidence based alternative report on Health situation and health initiatives at Global level was endorsed. David McCoy and Lexi Bambas would circulate a comprehensive idea draft on this report and the process of its evolution for identifying partners and collaborators.

f. A short dialogue was held with Dr. Bo Stenson of the GAVI Initiative (Global Alliance for Vaccines and Immunization) and PHM concerns about inadequate Health systems, Research in the GAVI initiative was discussed.

[This report brings together the key initiatives that the PHM secretariat coordinator was kept informed off. A large number of smaller group discussions and one to one meetings were held by PHM participants with WHA delegates and WHO units and others. This will be compiled and included in the next communication. All delegates are requested to send us any contribution to the next communication particularly focusing on any omissions or any other initiatives or meetings that have been omitted].

NOTES ON THE NGO BRIEFING

Specific recommendations and questions to the WHO have been underlined in bold.

1. Eva Wallstrom, External Relations and Governing Bodies: A new WHO Policy for relations with NGOs.

Dr. Wallstrom explained that the development of a new policy for WHO relations with NGOs emerged in response and concern that the process to establish official relations has been too complex and lengthy, that work reports have been delayed because of this, linkages have been personalised rather than institutionalised, and that while many NGOs have working relations, few have official relations. Additionally, guidelines needed to be developed for working relationships, and stronger linkages at regional and country levels built. Finally, the information available on each NGO needs to be provided transparently.

The new policy framework includes

1) accreditation (criteria, privileges and responsibilities)

2) collaboration principles

3) framework supplemented by guidelines, database of collaborations and NGO information, and improved communications

Questions and comments from the floor:

1. Recognising the importance of conflicts of interest, we welcome clarifications on roles and interests of individual NGOs. This is especially important since many NGOs, including humanitarian NGOs, are starting to have business people on board. Perhaps it would be possible to create separate categories, e.g. multistatals, PPPs, etc. **How will WHO categorise the NGOs, and how will their role in industry be made transparent?**
2. The inclusion of NGOs with different interests, including private interests, is not a problem, but transparency is important. **Would it be possible to have two entry-points, to clarify roles and interests?**
3. **Could you clarify what the "code of conduct" NGOs are expected to follow is?**
4. There is a long-standing need to separate public and private interests, so perhaps we could have a separate category for the private sector. The policy is trying to create safeguards, such as through the "conflicts of interest" statements, but these are not enough to be reassuring. There is still a clear need for concern, expressed by NGOs, regarding undue business interest in public interest areas, e.g. the role of the sugar industry in influencing WTO policy, and implications for health. **What will happen when groups like this continue to undermine the work of WHO?**
5. PHM agrees with the need to differentiate between different types of NGOs and their interests, and asks for **clarification on the guidelines**.

Response by Wallstrom: There is a clear message coming across regarding distinctions between types of NGOs, and this is an issue WHO looked at, but it was very difficult to create strict categories because decisions can be subjective (e.g. does some corporate funding necessarily mean an NGO has a business interest?). We decided that improving transparency by providing information on the NGOs such as Board composition, membership, and funding sources, is the most important way to support such distinctions. Since the Secretariat has the discretion to meet with groups or not, they will be able to use this information to guide building relationships.

Response by Yach: We usually use three types of consultations, for different purposes, which disclosure will help clarify: including corporate, public interest, and trade association.

Response by Quick: WHO has a fairly clear understanding of "who is who", and we work in different ways, including with industry. For instance, following a shared interest in getting a low price for medicines, we would try to assemble a balanced group, including industry but also HAI. But when we work with industry, we have a purpose.

2. Derek Yach: Framework Convention on Tobacco Control

Dr. Yach provided a brief history of the development of the FCTC, including what he thought were the most important factors for its success, such as the early concerted efforts of Ruth Roemer, the political leadership of Dr. Brundtland, the strategy to try to create a treaty rather than an agreement, the linking of the effort to WHO's constitution, the role of NGOs and mobilisation of civil society in the initiative, key

publications documenting abuses of tobacco companies and emerging knowledge of health harms, involvement of groups at the grassroots level even outside of public interest groups (e.g. athletics associations' ban on advertising), strategically limiting opposition and debate, advertising campaigns (such as the Truth in Advertising campaign), documentation and public awareness of the criminal activities of tobacco companies and their efforts to disrupt meetings and progress (e.g. Profits over People), and funding of essential actions (including mobilising funds for governments to be able to prioritise the issue).

It is important to note that we have been able to keep strong language in the FCTC, including in the first sentence, giving priority to countries' rights to protect public health, and to use wide international cooperation in implementation. In terms of implementation, the fact that monitoring of compliance has been included will be useful, as will liability issues, the participation and explicit role of civil society, and the gender dimensions of the issue. Still, we must anticipate the future responsibility of tobacco companies, and our vigilance in implementation, monitoring, and accountability needs to be strong.

Questions and comments from the floor:

1. Tobacco was not an issue for consumer groups 5 years ago, but CI is very glad we decided to support the issue and the FCTC. We should recognise that part of the success of the FCTC is due to Dr. Yach's commitment to working with civil society groups with a strong public interest. **Perhaps there is room for WHO to define "International NGOs" during accreditation as a way to create additional future collaborations on issues like this.**
2. Congratulations on the treaty. We would like to **recommend that the FCTC be immediately passed, that WHO agree that no UN Agency work in cooperation with the tobacco industry, that you continue to work vigorously with grassroots groups for monitoring and implementation, and that we take the lessons of this experience so that the FCTC paves the way for other treaties of express interest to public health and that place people's health first (e.g. a treaty aimed at the military industry)**.
3. **How will you support member countries as they move toward ratification and development of laws?**
4. This is a courageous move, and we look forward to its implementation. Perhaps the UN should consider not hiring smokers. (!)
5. The FCTC provides a model for building on the protection of public health policy from commercial interests, and highlights the importance of surveillance.
6. As a representative of the International Alliance for Women, I am pleased with the strong gender dimension; I hope that this **emphasis on gender will not be lost in implementation**.
7. We want to re-affirm the importance of transparency and differentiation of NGOs. The FCTC has a good track record, which should be expanded in other WHO policies.
8. **How will WHO help us to implement this in war conflict areas?**

Response by Yach: In response to the need for transparency of NGO interests in this effort, we used a U.S. database to identify NGOs with tobacco interests, and this was extremely helpful. But it is important to remember that we need not only "forms", but a culture of sensitivity to the issue of private interests.

Some additional information: Monday: Seminar on implementation, and the release of two books: guidelines for countries and a World Bank document on 6 successful case studies in implementation. The Commonwealth is trying to put together a group of lawyers who could support countries in implementation and development of laws.

3. Andrew Cassels: WHO and The Millennium Development Goals

Dr. Cassels mentioned some background on the Millennium Development Project, including that while health is central to the MDGs, the targets and indicators were put together rather quickly; it is clear the goals will not be achieved in some places (specifically south Asia and sub-Saharan Africa) without significant efforts; and WHO is involved in a number of issues including maternal health, AIDS/Medicines, Water/sanitation, and environmental health. This is not new work for WHO, but is rather a lens through which to view ongoing work. Though the goals are health outcomes, health systems are at the center of those goals since they are necessary for achievement. Finally, achievements need to be reliable, comparable across countries, and transparent.

He also mentioned a few important issues he thought would be debated this week. The indicators could use improvement: WHO's approach has been that the indicators chosen are important and cannot be ignored, but there need to be complementary indicators. The goals are expressed in terms of absolute

achievements and do not address issues of equity and relative achievements based on local challenges. The work has huge demands for information, since it is necessary for reporting. The MDGs are incomplete, and do not address health systems, reproductive health, and noncommunicable diseases.

In WHO, the MDG's have been used as shorthand for improvements in health overall. WHO has argued for inclusion of overall rates of disability and mortality to be included in the targets/indicators, and that the MDG's are just one project which should not distract us from other important work and projects. (Later, it was elaborated that the goals/targets/indicators could be interpreted in two ways: broadly, as the kinds of standards we should be able to see through our general work, or narrowly, as specific activity-orienting achievements; WHO is opting for the former interpretation, suggesting that the goals should not distract from general improvement in health and strengthening systems.)

Investing in health vs. investing in health systems: WHO prefers to include both.

Target setting and local context: targets should be adapted to national circumstances.

Resources must be increased to achieve goals.

Poverty reduction and PRSPs: 70 countries are developing PRSPs, and health is either not getting enough space within the work, or not enough detail, or the work is not integrated with the MDGs. WHO is trying to develop a political forum where disparate activities could be "knitted together" to become more focused.

Accountability cuts both ways: on the agencies to provide the resources and on the countries to do to the work.

Questions and comments from the floor:

1) **Health achievements require more than a biomedical approach, for example infant mortality** requires strengthening of nutrition, agricultural trade is undermining nutrition and food security, and pregnant women must be encouraged to eat first instead of eating last. The **indicators are not specific enough to guide community level interventions.**

2) We are disappointed that the WHO document makes no reference to Alma Ata. WHO has withdrawn its support for Primary Health Care and for Alma Ata in this, the 25th anniversary year. Instead, health is being used as a tool for economic development rather than a human right. The neoliberal actions undermining Health For All are absent from discussion. **PHM seeks reconsideration of the MDGs and Commission on Macroeconomics and Health to strengthen attention to Primary Health Care, Alma Ata, and Health as a Human Right.**

3) PHM's experience with communities suggest **we need comprehensive PHC** and not vertical, disease-based programs. We need **community-led development**, which Alma Ata provides a framework for, and we also need greater attention to inequities. WHO has a clear decision to make, and should remember its responsibilities to people.

4) The 1993 WHR found that extreme poverty is increasing. Since then, we have seen a move on privatisation of water, and the number of people with less purchasing power is increasing. These factors that affect health negatively should be dealt with in this context.

5) In reference to Goal 8, without equitable development, and without addressing macroeconomic forces operating at the supra-national level, the health goals of the MDP will not be met. The inclusion of Jeffrey Sachs as the leader of the analytical work of the MDP is disturbing, given that forces such as the WTO were not mentioned in the synthetic report for the Report of the Commission on Macroeconomics and Health. **This work must be used to improve justice, and should not be organised as a form of charity work.** Another disturbing issue is that on the Task Force for Nutrition, half of the members are from Monsanto, and there is little civil society representation. Interestingly, UNICEF's conceptual framework was changed by this group to exclude the role of global forces in shaping health at the individual level, suggesting the bias against attending to macroeconomic forces. **We would ask that WHO recognise that Goal 8 is directly related to health, and is the paradigm for shaping progress.**

6) There is a real **need for health resources indicators as well as outcomes indicators**. The comments on the accountability of governments is welcome, but **what is missing is the accountability of donors**, including the Banks. **We would also call on WHO for research on the impact of interventions, and an analysis of the impact of the past 10 years of using DALYs as an organising framework for health systems resource allocations. Finally, we would ask that such models be left behind and a rights based approach be adopted.**

Response by Cassels: Local action and context-specificity is indeed needed, as is addressing global issues such as agriculture. In relation to PHC and Alma Ata, we don't see WHO as turning away, but don't see a need to turn back either. The values are still there, in an up-to-date context and resource framework. Today's Development environment shows Health and Human Rights is gaining prominence, which is important. It would be important to look at how exclusion plays a role, and how it might be reduced. In response to the issue of health systems, health systems are essential, but it is difficult to get backing for addressing the issue if they are too complicated, which has been a problem. In relation to Goal 8, it is important to have accountability, but it is difficult to develop indicators. In fact, because of Goal 8, some countries did not want to sign onto the project. Finally, the accountability of donors is important and we need to monitor these financial flows as well as other inputs.

4. Jonathan Quick: Intellectual property rights, innovation, and public health

Dr. Quick mentioned the highlights included in the Brief, including public health needs for innovation, new ideas, policies, and programs, and that research priorities need to be on real health needs. (Dr. Quick closely followed the Brief that was distributed, so his comments have not been reproduced here.)

Questions and comments from the floor:

1. We very much appreciate that WHO is looking at this issue. The FCTC shows what WHO can do when it aligns with public health rather than industry, and **we would like WHO to work for bringing back a balance between the Global Patent system and values for health and welfare**, which have been undermined by TRIPS. **In the immediate context, we would like WHO to strengthen its role and take a more pro-active position in patent rights, and also to look at the logjam regarding TRIPs created by entrenched interests**—despite claims of flexibility in the Agreement, this flexibility does not exist once negotiations begin. Although public health interests and TRIPS may not be contradictory in theory, in reality they are proving to be in conflict.
2. So far, consumers have been unable to access possibilities for patents [on public goods] because it is expensive. **There should be a way at least for reports and decisions to capture and reflect consumers' viewpoints**.
3. Though we were excited about the DOHA Agreement to allow production of medicines, this victory has not materialised as countries have not taken advantage of it. **We would like to know if WHO will support action on this.**
4. The amount of money spent on research for medicines is a gross mismatch in relation to the improvements generated. Prices of medicines have increased, as have disease burdens. WHO should recognise its role in protecting us.
5. Congratulations, but this issue should have been brought to the fore 10 years ago. Also, **Health Ministries are not involved at all in this issue of product patents, but should be**.
6. TRIPS violates Human Rights, and we would like WHO to look into this issue. Additionally, the **efforts to dilute the DOHA Agreement should be fought against, and the Agreement protected as it stands**.
7. We do expect WHO to be the organisation to protect access to medicines and health, and not to protect industry. **Noting trends in patenting knowledge and natural plants, etc., we would ask how WHO can allow this?**
8. **How will IPR protect traditional medical practices and medicines from being commercialised and reserved for the market economy?**

Responses from Quick: Several themes have emerged, including public health and access to medicines. We have met with health, trade, and patent groups together, to "get the health people educated" on the issue, but we need more cross-discussion. We have started mapping country responses, and find that countries are not putting safeguards in place; we are hoping the mapping will stimulate action. WHO's response to the problem with paragraph 6, the manufacture of generic pharmaceuticals by poor countries, is being published, and pharmaceuticals are recognised as a special case for trade. Finally, WHO is very concerned with issues of traditional medicine becoming commercialised, and a discussion has been arranged on this issue for this week.

STATEMENT AT WORLD HEALTH ASSEMBLY, MAY 2003, PEOPLE'S HEALTH MOVEMENT IN COLLABORATION WITH CHURCHES ACTION FOR HEALTH

WORLD HEALTH ASSEMBLY
COMMITTEE – A
Item 14.18
Tuesday, 20th May – 9am

People's Health Movement Response to *International Conference on Primary Health Care, Alma Ata : Twenty-fifth anniversary, Report by the Secretariat*

Comments on introductory sections

PHM believes that WHO has progressively withdrawn from the true spirit of the Alma Ata vision of PHC. Increasingly selective and disease focused, donor driven initiatives have been supported at the expense of people centered comprehensive approaches that both provide basic care and tackle the underlying causes of disease and seek to promote positive health. PHM calls on WHO to return to the original vision.

The document states that PHC is about the health of the disadvantaged but ignores the following:

- Inequities are increasing – the gap between developing and developed countries is growing.
- Inequities within many countries are also increasing, despite, in some cases, overall increases in life expectancy.
- In many African countries life expectancy is declining rapidly (HIV / AIDS has offered new challenges for PHC and this is not acknowledged in the resolution).
- The absolute number of people living in poverty has increased worldwide and sharply in some regions.

The analysis of the People's Health Movement indicates that the major cause of the growing inequities is the increasingly unipolar world economic order and its impact on the lives and livelihoods of people around the world. Neither the global report nor the resolutions acknowledges this impact. Until the world is characterized by FAIR economic and trade relationships, Health for All can not be achieved.

Greater pluralism in funding has meant less access for the poor to health services as a result of:
Introduction of user fees
Privatization of health services
Privatization and contracting out of services provided within the public health system

The imposition of health sector reform with its dominant focus on efficiency and cost effectiveness has further resulted in:

Decentralization without adequate resources leading to a decline in health system capacity as evidenced inter alia by sharp reductions in basic vaccination coverage globally since 1990.
Lack of investment in publicly funded primary health care systems and no attention to leadership and management development for PHC.

Although many countries see PHC as a policy corner stone and a framework for health care delivery, this commitment has not been reflected in a reallocation of resources away from the hospital sector. The PHM considers that States should be responsible for the funding, organization and delivery of PHC. Many NGOs provide services to marginalized communities in the absence of government funded services. PHM believes that governments should support public funding for PHC, adapted to local need and based on comprehensive models stressing community participation and encouraging community development, social action, popular education and direct service delivery.

Amendments to resolutions

Requests Member States:

i. To ensure the development of PHC is adequately resourced through a targeted reallocation of resources to non-hospital care and local community based health initiatives involving other sectors. Member States should demonstrate this by setting specific targets to allocate extra funding to community based services and monitor the impact on reducing health inequalities.
ii. To accelerate long term improvement of human resource capability through increasing resources and activities for capacity for implementing comprehensive PHC systems (rather than selective PHC focused on donor driven disease specific initiatives) within both government and non-government services.
iii. To enhance the potential of PHC to tackle the rising burden of chronic conditions through health promotion including illness prevention and disease management but not at the expense of comprehensive initiatives to tackle the increasing burden imposed particularly on the poor by communicable diseases including HIV / AIDS, TB, Malaria.
iv. To create mechanism, including the allocation of resources and training, for the active involvement of communities and NGOs for PHC.
v. To support research in order to identify effective methods for strengthening PHC and linking it to overall improvement of the health system and to the reduction of health inequalities.

Requests the Director – General

1. To re-affirm the principles of the comprehensive PHC approach as enriched in Alma Ata into the activities of all programmes.

2. To review the Millennium Development Goals and the recommendations of the Commission on Macroeconomics and Health in terms of their compatibility with the principles of PHC as enshrined in Alma Ata, especially health as a human right rather than primarily as an input to economic development.
3. To evaluate different approaches to PHC by both government and NGOs and to identify and disseminate information on best practices to government and community actors in PHC in order to improve implementation.
4. To instruct WHO personnel in Geneva, Regional and Country Officers to engage more proactively with both government and NGO PHC initiatives to determine the capacities they require in order to meet new demographic, epidemiological and socio-economic challenges.
5. To continue to provide support to countries for improving the quality and quantity of health personnel in order to enhance access to comprehensive services, especially for the poor.
6. To lay renewed emphasis on support for the implementation of locally determined models of PHC that are flexible and adaptable.
7. To organize a series of meeting on future strategic directions for PHC that capture grass roots experiences of PHC and involve the People's Health Movement.

A shorter, edited version of this statement was presented at the Committee A Session (discussion on Primary Health Care)

THE CHURCHES ACTION FOR HEALTH AND THE PEOPLES HEALTH MOVEMENT RESPONSE TO INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE, ALMA ATA:
Twenty- fifth Anniversary; Report by the Secretariat.

The Peoples Health Movement International welcomes the adoption of a resolution affirming the Primary Health Care approach as the cornerstone of national health systems. PHM believes, however, that the UN Organisations have not always adhered to the true spirit of the Alma Ata vision of Primary Health Care. Increasingly selective and disease focused, donor driven initiatives have been supported at the expense of people centred comprehensive approaches that both provide basic care and tackle the underlying causes of disease and seek to promote positive health. PHM calls on WHO to return to the original vision.

The document states that PHC is about the health of the disadvantaged but ignores the following:

- Inequities are increasing the gap between and within the developing and developing countries.
- The absolute number of people living in abject poverty has increased worldwide and sharply in some regions.

The analysis of the Peoples Health Movement indicates that the major cause of the growing inequities is increasingly unipolar world economic order and its impact on lives and livelihoods of people around the world. Neither the global report nor the resolutions acknowledges this impact.
The imposition of health sector reform and pluralism in funding, with their dominant focus on efficiency and cost effectiveness has further resulted in;

- Decentralisation without adequate resources leading to a decline in health system capacity as evidenced inter alia by sharp reductions in basic vaccination coverage globally since 1990.
- Lack of financial support to publicly funded primary health care systems and no attention to leadership and management development for Primary Health Care.

Although many countries see PHC as a cornerstone and a framework for health care delivery, this commitment has not been reflected in a reallocation of resources. Many NGOs provide services to marginalised communities in the absence of government funded services. The Peoples Health Movement believes that governments should support public funding for PHC, adapted to local needs and based on comprehensive models.

Joint NGO response to US proposal on Intellectual Property Rights (IPRs), Innovation and Public Health at the 56th World Health Assembly

Médecins Sans Frontières, Health GAP, Health Action International, ACT UP Paris, Peoples Health Movement, OXFAM, Treatment Action Campaign, Canadian HIV/AIDS Legal Network, Stop AIDS Now!, Stop AIDS Alliance

May 21, 2003

The United States proposal asserts that strengthening intellectual property (IP) protection is the best way to stimulate investments in R&D. This assertion disregards mounting evidence to the contrary: the emerging global consensus that the current system of IP protection is failing to stimulate R&D for diseases of the poor. Of the 1,393 new drugs approved between 1975 and 1999, only 16 (or just over 1%) were specifically developed for tropical diseases and tuberculosis, diseases that account for 11.4% of the global disease burden.

Patents that ensure IP protection are part of a complex system that can motivate investment in R&D under certain circumstances, in particular when a profitable return on investment can be expected. However, patents will not stimulate neglected diseases R&D precisely because the people who suffer from neglected diseases do not have substantive purchasing power, and cannot constitute a profitable market.

In 2002, the UK government commissioned an independent report—the Commission on Intellectual Property Rights (CIPR) Report—which concluded that "[a]ll the evidence we have examined suggests that [IP] hardly plays any role at all [in stimulating R&D], except for those diseases where there is a large market in the developed world. The heart of the problem is the lack of market demand sufficient to induce the private sector to commit resources to R&D. [The] presence or absence of IP protection in developing countries is of at best secondary importance in generating incentives for research directed to diseases prevalent in developing countries." However, IP protection is clearly recognized as a barrier to access to existing medicines because it increases drug prices and hampers generic competition.

The proposals contained in this draft are based on an almost blind belief in the IP system—without regard for the reality for patients in desperate need of newer, more effective health technologies and access to existing essential medicines. In view of the HIV/AIDS crisis, and the massive problems expressed by many WHA delegates in guaranteeing equitable and sustainable access to affordable antiretroviral medicines, this text gives the impression that the US has lost touch with reality.

It is incomprehensible that the proposal makes no reference to the WTO Ministerial Declaration on the TRIPS Agreement and Public Health (Doha Declaration), no reference to the need to find an economically viable, workable solution to the Paragraph 6 (production for export) problem that will, consistent with the Doha Declaration, ensure access to medicines for all. The US proposal suggests that WHO should refer Member States to the WTO and WIPO for technical assistance, when countries have clearly and repeatedly indicated that they want WHO to play a much stronger role in order to ensure pro-public health national legislation.

We urge WHO Member States to reject this proposal and work towards a resolution that makes the health needs of people in developing countries the central focus.

Statement on IPR

Intellectual Property Rights are ideally designed to balance the Rights of the Patent holder with the obligations towards society. Patents are meant to promote both innovation and disclosure of patented information and its dissemination.

Unfortunately the IPR regime being enforced today through the TRIPS agreement under the WTO has been unable to maintain this balance. While the evidence regarding the ability of the TRIPS mandated Patent system to promote innovation in absolute terms is still equivocal, there is strong evidence that the kind of innovation it promotes does not address real health needs. If we look at the data on new drugs introduced in the last 20 years, we learn that of 2257 drugs introduced only 7 are major therapeutic innovations and 67 are important advances. In contrast 1427 drugs are superfluous as they do not add to clinical possibilities offered by existing products. On the other hand the last drug for Tuberculosis (a disease that kills close to 2 million people every year across the globe) was discovered more than twenty five years back.

On the other hand [the fact that] monopolies [that are] created by Patents is pushing drug prices beyond the reach of people who actually need drugs. It is a truism that people who need drugs most are the least likely to pay for them. The present Patent regime ensures that drugs researched are those for which a small minority can actually pay the very high costs that patent rights ensure.

Traditionally the level of patent protection in countries was a function of the stage of industrial and scientific development in the country. Historically, most developed countries today have made use of lower level of Patent protection to build internal capabilities to innovate and produce new pharmaceutical products. This kind of a differential system, as opposed to the harmonised system in force today, also allowed developing countries like India and Brazil to build a very strong indigenous pharmaceutical industry.

The inability of the TRIPS council to find a solution to para. 6 of the Doha declaration points to the inflexibility exhibited by the votaries of the present IPR system. It also points to the enormous power that is being vested in a handful of research based companies who are able to decide what drugs will be researched.

While nobody would argue against the need to promote innovation and provide incentives for doing so, the present system of IPRs is skewed heavily in favour of the patent holder. This is actually today acting as a fetter to the promotion and dissemination of knowledge that is vital for the health and well being of millions.

There is a need to bring back a balance into the global Patent system that places a premium on health and welfare, rather than commercial objectives. Only such a balance can really ensure that Patents are really able to promote innovation and ensure disclosure, leading to the development of drugs that meet real medical needs and are accessible to all those who require them. Towards this end the immediate aim should be to facilitate and promote the use of flexibilities in the TRIPS agreement that the Doha declaration clearly enunciated, including especially the use of provisions related to compulsory licensing and parallel imports. Further, a speedy solution to the para 6 impasse needs to be sought that addresses the urgent needs of countries without capabilities to produce drugs.

PHM Meeting with Dr JW Lee
Director-General Elect of WHO
World Health Assembly, Geneva
22 May 2003
Meeting Notes

Present:
Representatives of the People's Health Movement
Dr. JW Lee
Dr. Jim Kim
Alec Irwin

Statements from PHM representatives:

The PHM represents more than 1000 grassroots groups from around the world, many of which do health work with the poorest of the poor.

The movement emerged via the first People's Health Assembly, in Bangladesh in 2000. In the symbolic year 2000, the Assembly met to sustain the legacy and spirit of Alma-Ata and the call for "Health for All." More than 14,500 people from many different countries and regions attended the Assembly. Case studies on health care from different parts of the world were examined and discussed. The Assembly produced the People's Health Charter.

The Charter and the PHM do not look at health in a narrow, limited sense, but focus on the wide set of factors and issues that determine health, including: war, the environment, development, and the full range of economic and social factors that influence health outcomes.

The PHM believes in WHO's inclusive definition of health. The Movement wants to be an active, critical partner of WHO—and if possible to help limit the influence of institutions such as the World Bank in the health sector! The PHM can contribute to WHO's efforts by bringing the grassroots community perspective.

The fundamental commitment to equity expressed in Dr Lee's WHA speech resonated with representatives of the Movement. Such a commitment is also at the heart of PHM's Health for All campaign.

Especially in the African context, HIV/AIDS and access to medicines emerge as the key health issues. We must not wait any longer in finding real solutions to these challenges. It is vital to focus on access to health for the poor.

The poor need clearer and more effective representation. In many cases, poor communities are neglected by their own governments. Governments must pay more attention to grassroots civil society. WHO must also do more to recognize and connect with civil society—not just states.

Public health conditions for many communities in the Middle East are undergoing serious deterioration, especially in Iraq and Palestine. US and Israeli aggression has

destroyed much health infrastructure. Earlier today [22 May], the Israeli army attacked a primary health clinic in the city of Nablus. The communities of this region look to Dr Lee for support and solidarity and ask him to see that WHO involves itself more actively.

PHM members from Asia take pride that Dr Lee has brought the WHO Director-General-ship to Asia. Many resonated strongly with the core messages of his acceptance speech. It is important to strengthen WHO country offices, to bring WHO close to the real problems, and to reinforce accountability.

WHO needs to maintain its independence, to critique national governments when necessary. This is very important. It is promising to hear that WHO will become more of a "listening organization." Too often in the past, WHO has been "far from the people, and far from God"!

The problem of an ageing population must be confronted now in many developing countries, as well as in wealthy societies. WHO should be prepared to focus more strongly on this issue.

The issue of essential drugs remains crucial. Bangladesh furnishes an important example of efforts in this area.

Public health cannot be separated from its economic context. The emphasis in coming years needs to be on growth *for the people*.

The PHM representatives thank Dr Lee for his humane response to Giuliana Chiorrini, the widow of Dr Carlo Urbani. "Go back to the people"—this must be the new humane attitude for WHO.

The next People's Health Assembly will take place in Porto Allegre in July 2004. PHM was disappointed when Dr Brundtland failed to participate in PHM events, after having promised to do so. The PHM is giving Dr Lee "15 months notice" for the next People's Health Conference in 2004—so he will have plenty of time to arrange his schedule!

Dr Lee's response:

Grassroots movements are enormously important, especially in the health field. These movements bring the views, feelings, and expressions of those who *really know*. It seems almost hypocritical for WHO people here in Geneva to be talking about poverty—here, as we pay $2 for a cup of coffee, while millions struggle to survive and sustain their families on $1 a day. For this very reason, we urgently need your input. We need to hear the voices of the communities you represent.

Some of you may initially have felt powerless. But by uniting your forces, you have reached a critical mass with this People's Health Movement. It is vital for WHO to listen to you and your communities. Thank you for coming.

Final message from PHM representatives:

75 PHM members from 13 countries have come to Geneva at their own expense, to let their voices be heard, and to bring a message of support. They are very hopeful, and they want to support Dr Lee as he begins his work as DG.

They hope that, as a symbol of his commitment to listening and cooperating with grassroots groups, Dr Lee will join the PHM's "Million Signature Campaign."

WORLD HEALTH ASSEMBLY - MAY 2003, GENEVA

- a report by Mira Shiva

The World Health Assembly is considered important by public health groups because it is the only time every country is represented over health policy concerns. Being organised by WHO the health arm of UN system.

At a time when the UN system is under threat of losing its role, with multilateral trade regimes and supranational bodies like WTO superceding collective decisions and commitments already made.

The 56th World Health Assembly was different because:

1. it marked 25th year of Alma Ata Charter on Primary Health Care.

2. it was selecting a new DG with the present DG Dr. Gro Harlem Brundtland retiring.

3. the Framework Convention on Tobacco Control (FCTC) coming up for voting with US threatening not to sign it.

4. WHA was being immediately followed by G8 Summit with Mr. Bush planning to stay in Geneva (not in France for obvious reasons). It was because of this that railings, barricades and rolls of barbed wire around US Embassy. Intensification of security with closure of many roads linking France, with closure of banks, all shops planned for that period.

5. the other difference with the WHA was that on the agenda was placed Traditional Medicine, WHO Drug Strategy and the most important Intellectual Property Rights (IPRs).

It may be recalled that Doha declaration on TRIPS and Public Health on September 21, 2001 gave public health priority over trade. It had been brought about with tremendous pressure from drug activists and some delegations from Southern countries. Since tremendous efforts have been made to dilute the Doha declaration led by US. The first salvo fired by us was defining public health to mean 3 diseases ie., HIV/AIDS, TB and Malaria.

Faced with challenge this has been increased to include a few more infectious diseases. Meanwhile through bilateral pressure many countries have been armtwisted to sign bilateral agreements with US, omitting the important TRIPS safeguards making their citizens vulnerable where access to medicines is concerned.

By 2005 countries like India, Brazil, Argentina etc., come under the TRIPS regime with the Least Developed Countries (LDCs)s coming under TRIPS by 2016.

The tragedy is that if the countries with no manufacturing capacity do not include "parallel imports" in their National Patent Law, or are not allowed to import cheaper generic equivalent, they are forced to buy drugs at several times the cost from the patent holder.

The shadow of G8 and the presence of Mr. Bush - American presence in Geneva is significant since it was the Trade Association of US, Japan and EU who had drafted the TRIPS agreement in the 1st place which was presented to the world by the GATT Secretariat in the Uruguay Round of GATT.

Registration for WHA was possible with the help from accredited organisations eg., IBFAN, INFACT, C.I., and W.C.C.. Screening of all delegates for SARS and its clearance was indicated with a green sticker on the registration badges without which entry into WHA committee rooms was denied.

On May 19, on receiving the Journal giving the WHA programme we discovered that besides Primary Health Care, FCTC, agenda items which we were expecting besides NGO's' relationship with WHO, there were 3 agenda items ie., WHO strategy on medicines, (14.8) TSM (14.10) and Intellectual Property Rights (14.9) (IPRs) listed for 26th. Since no one was aware of its inclusion in the agenda -- most PHM, HAI, MSF, CI persons were leaving before that.

Having had the experience of Nairobi International Consultation of Experts on RDU in 1985, WHA 1986 when a strong resolution on drugs was not allowed to pass inspite of most delegations wanting it having seen the efforts at derailing the efforts of rational drug campaigners in 2000 and 2001 WHA by the pharmaceutical companies by offering discount for few LDCs on anti-retrovirals and creating a hype about Global Health Fund (GHF) and presenting it almost as a substitute for ensuring access to medicines which it is not, and never will be. Between the `false hopes' of getting the drug needs met through GHF and not pursuing the TRIPS safeguards and between bilateral pressures which are resulting in omission of the TRIPS safeguards -- the problem related to access to medicine and their high price will be grave.

On going through the Traditional Medicine paper, Item No. 14.10the inclusion of complementary medicine and alternative medicine to Traditional Systems of Medicine like Ayurveda -- was undoubtedly set for creating confusion. The omission of any mention of Biopiracy or appropriation of indigenous knowledge and resources was significant.

On May 21st, Brazil put in a resolution and it struggled hard to rally other countries who stood to loose from the TRIPS regime.
On the following day US put in a resolution.

The IPR agenda scheduled for 26th was suddenly put on 23rd with if time permits and then again on 24th. It was suddenly shifted to the inside pages for discussion on Saturday.

The Saturday afternoon discussion was basically on confrontation between US and Brazil. In the meantime other countries eg., Bolivia, Brazil, Equador, Indonesia, Peru, South Africa on behalf of number of WHO African region and Venezuela.Thailand etc., decided to join Brazil.

I met Mrs. Sushma Swaraj thrice and also Dr. Naik, handed over material related to biopiracy and also the joint statement on IPR by HAI, CI, MSF, OXFAM, PHM etc. At the time the IPR discussion was taking place, the GHF meeting apparently was also fixed. Since I met Dr. Naik and reminded him that the IPR discussion was in Room II, he

said he had to go for the GHF (at the same time) and said that Dr. Malti Sinha, Secretary, ISM would go for IPR.

Nobody from India went for the Saturday afternoon discussion and Brazil left.

Mrs. Sushma Swaraj did make a statement on behalf of India reporting TSM that India would like to see Traditional Systems like Ayurveda which are already codified, to be addressed differently from complementary and alternative medicine. She also mentioned that includes medicinal plants were being put in data bank and this was patent complaint. She did not mention biopiracy nor appropriation of indigenous knowledge.

The WHO strategy on medicines was discussed. Many countries congratulated WHO for having contributed in this area, helping countries with their essential drug lists etc.

Some countries mentioned that essential medicines was an important component of PHC and that increasing costs and non-availability, due to financial constraints was a big problem for many developing countries specially African countries.

US as expected talked abut counterfeit drugs and need for stronger IPR, and need for innovation, high costs of innovations.

On behalf of CI, representing consumer concerns, I read the statement.

IPR was discussed on 26th. US pressed for stronger patent regimes, it talked about innovation and need for more innovation, more resources, using SARS as an example.

It also wanted to see WHO Consultants who were actually helping developing countries to use the TRIPS safeguards much to the obviously more annoyance of US to be removed and wanted consultants with "diverse" obviously more pliable views to be involved.

The WHO document on WTO and public health was diluted significantly and ultimately brought out as WTO/WHO publication.

During the IPR discussion the NGO observer section was full of pharma company representatives, who were basically also wearing the yellow NGO badges. Reports of Merc pharma representative having met many delegations also came to light. US delegation was huge and as always with large number of drafters who take on the drafting. Since it could not be finished, it was moved to the 27th morning and some smaller countries who were not involved in the discussions (partly due to non-availability of translation and partly due to other agendas where delegates were required wanted to give their views. Only by countries with larger delegation can ensure that their representatives can sit in the Committee Rooms A&B where major discussions and other meetings take place and can also ensure presence in the discussions.

Brazil's perseverance was admirable, they provided leadership for the developing countries. Pakistan, Zimbabwe, South Africa, Philippines and Equador made good interventions on the subject. Dr. Naik on behalf of India stated that the health minister should be kept involved rather than commerce since these issues were related to health. It was clear that it was either out of a conscious decision not to say anything

contradictory to US stand on it was lack of understanding of the IPR issue that a more strong and comprehensive intervention was not made.

It was pity that all major public interest organisations involved in IPR left before the IPR debate. It was a greater pity that due to non-accreditation status, the joint statement which was prepared could not be made as it had to get a clearance from the accredited organisation and handed over to the WHA Secretariat 24 hrs earlier.

Only Carmelita of CI and I were there to hold the fort surrounded by pharmaceutical company representatives. Others were from IBFANB, GAP. International Federation of Pharmaceutical Manufacturers Association (IFRMA) made a statement obviously focussing on their contribution to innovation and public health.

(In future, organisations involved in the issues should stay till the end.)

As many statements as possible on this issue should be made to indicate the concerns of the world's poor majority's need for medicines.

Accredited organizations must intervene or allow others to do so. Since we have limited resources every opportunity must be intelligently used.

The WHA and IPR debate was critical because of Doha dilution process and the upcoming Cancun ministerial meeting.

Those individuals within WHO who are sticking out their necks and risking their jobs really need to be congratulated and made to feel valued and appreciated.

If public health and IPR cannot be defended in the WHA where majority of affected parties developing countries facing the dilemma are present, it is unlikely that it can be defended in WTO or in Regional Trade Agreement.

I stayed on at WHA delaying my departure realising the importance, but also realizing that this concern is unfortunately not showed nor addressing the issue is on the organizational agenda unlike the FCTC, Codex etc.which is being addressed by many. Faced with a similar situation, I would stay on and do my bit again.

Other important issues discussed at WHA were Primary Health Care. Many countries felt the importance of PHC including Finland and congratulated WHO for keeping it alive. An attempt to substitute PHC as `close to client services' was questioned.

The FCTC discussion was the most animated and US which was unwilling to sign FCTC earlier agreed to so at the last minute. The anti-Tobacco activists were present in very large numbers, very well coordinated and many being old hands were very experienced. They had back up from their countries, their organisations and WHO added to their performance. There was great clapping and joy on FCTC being passed. Dr. Srinath Reddy was one of the 6 persons honoured for their contribution.

Nursing and midwifing agenda item 14.11 again brought out the brain drain of qualified nurses from poor countries to the developed world where they are paid much less than their own nurses and made to work and live and conditions not very appropriate reflecting double standards. The need for adequate compensation for travel of nurses was raised and also the need to increase nursing training.

The NGO representation in WHO was another topic as flood gates are being opened to Corporation fronts as well as `for profit organisations'. The public interest groups, who do a lot of hard work risking their necks with shoe string budgets are very uncomfortable. The added clause that accreditation would require information about sources of funding is not acceptable to the NGOs doing watch dog roles at shoe string budgets with moral and financial support from friends and small groups.

SARS, influenza and also international regulations were discussed.

Small pox virus being kept in US, USSR different labs was also discussed. Many feel the virus should be `destroyed' as it could be used for biological warfare. Others feel ti should be kept in case any outbreak occurs so that vaccines can be made. Incidentally Indians on being told has destroyed its small pox vaccine making infrastructure and capability.

PEOPLE'S HEALTH MOVEMENT (PHM)

IPHC and PHM met prior to the WHA.

PHM seminar took place in WCC.

There were large number of participants -- many of whom stayed for entire part of WHA.

RAMBOISM

The need to show a common front is increasingly being felt by most in view of the increasing `Ramboism' decreasing democratic spaces, increasing trapping of NGOs in non-view, short time projects with reductionist biomedical approach, the entry of `fund seekers' with `give fund will work' approach. The public interest groups are few, who have a good grip on the issues, deep commitment, intelligence and guts to confront.

The PHM participants constituted of those who had been working in their regions and were linked to PHM. Presentations were made. Unfortunately time for discussion was limited.

Distances and commuting was a problem.

Large number stayed in John Knox, Spanish groups and a few of us stayed at Mandat which was cheaper further away and required walking 1 to 1½ kilometers from the bus stop, the frequency of bus was 1 hourly. The weather got raining at times.

The food was mainly bread for a vegetarian who could not eat the non-veg dishes it was rough. Eating out because of cost of food and the bus problem and long hours of meetings and discussions at the Palais was not an option.

Most PHM persons were not geared for lobby work, those who could unfortunately left midway.

PHM planning meeting was held in John Knox after the PHM seminar.

I was asked to deal with HIV/AIDS, TB, Malaria initially but at the meeting I was asked to deal with Drugs and Patents.

Sudha dealt with women's issues.

Rosalie Bertel was specially invited to deal with conflict and militarization. She has been involved as member of the International Medical Commission in Bhopal and is very much respected and loved as a person.

There were many others.

PHM, Geneva were local hosts and Ravi Narayan coordinated the meeting.

COMMUNICATION – I **Date: 24.06.2003**

Dear Steering group members,

Greetings from People's Health Movement Secretariat (Global) at CHC, Bangalore!

I. FOLLOW UP TO PHM/WHA GENEVA 2003 EVENT

a) The PHM Geneva event at WCC and WHA were strategic opportunities for being together and evolving further PHM strategy for the months and years ahead. A larger number than expected (82 people from 30 countries) attending this get-together and there were many occasions to get on with the steering and the strategy evolving responsibility

b) We have circulated earlier a report of the main events and decisions but this communication is specifically directed to all the Steering group members and includes many ideas that also emerged in a host of small group discussions We had with so many subgroups at different times during the packed week

c) We in the Bangalore secretariat (building on the nurturing role that Qasem and GK had already played for over 2 years since the Assembly) have taken a little initiative to build up a collective solidarity; promote an enthusiastic response; and revive some drooping spirits and reaction fatigue in some regions. From the enthusiasm that we experienced at Geneva, we are more than convinced that this revival phase is over

d) Now the secretariat's main focus will be on facilitating / coordinating, communication and information and liaison as you all start to take more responsibilities for many of these initiatives

e) In addition we are seriously engaged in putting all this together in a logical frame and evolving a funding proposal as well. We need all your support for this and for the fund raising that will follow. Prompt responses to these communications will help greatly in evolving a strategy with clarity and detail.

f) The evaluation report, which is due, soon will greatly help this process as well. As you bring clarity and collectivity to all the tasks for which you have volunteered or have been nominated – the movement will grow and the collective solidarity will be enhanced.

II. EVOLVING A PLAN OF ACTION [JULY 2003 – JULY 2004]

a) The next fourteen months are a very important phase for the People's Health Movement as it has emerged beyond its infancy (under two) and moves into the toddler years (third and fourth year), which are also the significant Alma Ata Anniversary year (2003) and the year of the next People's Health Assembly (2004). Unlike the last time before the People's Health Assembly – (when the core planning group emerged as a coming together of interested networks and selected and nominated individuals and later divided into a analytical, planning and funding group) this time an organizational structure for Steering group of PHM has evolved consisting of representatives of the founding groups (eight networks and organizations) and the regional facilitators of the thirteen PHM emerging regions

b) The plan of action outlined in a series of shorter communications that follows will build on the capacities and responsibilities of the Steering group and pull in resource persons and volunteer PHM members from all the regions. **Each member of the Steering group has, therefore, a very important, responsible and proactive role to play to ensure that this plan of action gets operationalised.**

c) Please give urgent attention to this plan of action and **WE WOULD REQUEST ALL OF YOU (We mean all of you!!)** to respond to these requests promptly. Please confirm your responsibilities and what suggestions you would like to offer on all these matters. It may seem, perhaps too much, with so little resources – but we believe we all have capacity, contacts both at regional and international levels; linkages with ongoing initiatives and networks and increasing credibility.

d) The Secretariat can only do as much as you all do to take responsibility, initiate collective dialogue and get on with the tasks. We believe we can do it. So let us get on with it!!!

e) The 12 tasks that we need to collectively evolve are as follows:

I. PROMOTING THE PHM STRUCTURE

A GEOGRAPHICAL CIRCLES:
B. DEVOLVING PROCESS/CLARITY IN SOME REGIONS

II. INCREASING SUPPORTIVE ROLE OF THE NETWORKS

III. PROMOTION OF ISSUE BASED CIRCLES

IV. ALMA ATA ANNIVERSARY INITIATIVES

A. COUNTRY LEVEL MEETING / DIALOGUE
B. PHM POSITION PAPER
C. THE MILLION FOR HEALTH FOR ALL SIGNATURE CAMPAIGN
D.PEOPLE'S HEALTH AWARDS
E.THE FILM – REVIVING THE DREAM

V. ALMA ATA ANNIVERSARY CELEBRATIONS MEETING IN IRAN

VI. HEALTH FORUM AT WORLD SOCIAL FORUM- MUMBAI, JANUARY 2004

VII. PEOPLE'S HEALTH ASSEMBLY – II (PORTO ALEGRE, JULY 2004)

VIII. TAKING ON BOARD THE PHM EVALUATION – SHARING THE LESSONS IN EACH REGION

IX. GLOBAL HEALTH EQUITY WATCH – CONTRIBUTING TO THE REPORT FROM THE REGIONS / NETWORKS

X. SUPPORT TO THE EVOLVING COMMUNICATION STRATEGY OF PHM

XI. FUND RAISING CAMPAIGNS TO SUPPORT GLOBAL, REGIONAL AND NATIONAL ACTIVITIES

XII. BUILDING COALITIONS WITH OTHER NETWORKS TO PROMOTE THE CONCERNS OF THE PEOPLE'S CHARTER FOR HEALTH

Note: The first three and items VIII, X and XI are organizational and Items Iv to VII an Item IX and XII are programmatic

f) You shall now receive in the next few days a series of communications on each of this with an attachment as further details. We have been working on these for the last few weeks since the Geneva get together. We have taken the liberty of allotting some of you to specific initiatives in addition to those who had already volunteered, just so that the responsibility and involvement of the whole committee is ensured. In some cases, country focal points or other PHM resource persons / contacts in an area or region have also been included. These are sometimes only suggestions and not binding. Some of you may want to change the area of involvement or join some area in which you are not shown. Just please feel free to do so, informing the secretariat of the changes or choices. Also you may want to suggest others to join these initiatives from your regions / networks. Please do so but after getting their ok for the same.

g) **SO AS A BEGINNING OF THIS IMPORTANT PLANNING AND FOLLOW UP EXERCISE PLEASE ACKNOWLEDGE THIS COMMUNICATION. THE REST WILL FOLLOW SOON. WE WILL AWAIT YOUR PROMPT RESPONSE TO EACH OF THEM. PLEASE ALLOT THE NEXT 2 WEEKS TO THIS COLLECTIVE EXERCISE SO THAT YOUR CONTRIBUTION WILL BE ENSURED TO HELP US BUILD A COLLECTIVE STRATEGY**

Thanking you in advance

Ravi Narayan
PHM Secretariat

Prasanna
Communications officer

COMMUNICATION - II

DATE: 27.06.2003

Dear Friends,

Further to our communications about a collective planning and action exercise being initiated by the secretariat, this is the second in the series of communications. This section contains the following 4 tasks out of the 12 listed in the earlier communication. PLEASE, PLEASE RESPOND.

I. Promoting the PHM Structure
II. Increasing the supportive role of the networks
III. Promotion of Issue based circles
IV. Alma Ata anniversary initiatives

I. Promoting the PHM Structure

A. GEOGRAPHICAL CIRCLES – Proactive Promotion:

As we move towards the next Assembly the first urgent task is the encouragement and proactive promotion of country level circles and regional circles. This will involve

a) A report from those already identified as facilitators or contact points on what processes of dialogue, communication and initiatives they have undertaken since the Assembly and especially in 2003, the Alma Ata Anniversary year.

b) The identification of contact points in countries that do not have any one designated as such. The encouragement to contact persons to organize a meeting or to use the strategic opportunity of an ongoing meeting in the country to organize a PHM session and identify the country level facilitator

c) In some regions, this process has to be taken forward till we identify the Regional Facilitator / Focal point from among a group of country facilitators.

Appendix A – Lists out the regional and country level facilitators as on 1st June 2003. Have we left out anyone?

Appendix B – Lists out the countries that are represented in each region at the first Assembly (December 2000) and the countries, which could be involved / mobilized from the region by PHA – II (July 2004). Any ideas of how the new countries can be mobilized?

Appendix C – Is an extract from a note on PHM organizational structure – (A people's web) about geographic circles, contact points and facilitators. Any additions or suggestions?

ALL COUNTRY / REGIONAL FACILITATORS / CONTACT POINTS ARE REQUESTED TO SEND US TWO SHORT REPORTS AS SOON AS POSSIBLE.

i. **YOUR PLANS FOR MOBILIZATION / INITIATIVES IN 2003-2004** (With reference to Appendix A, please comment on countries in your region, which are already involved or contacted and what you propose to do for the other countries).

ii. **A BRIEF REPORT ON ALL THAT HAS TAKEN PLACE SINCE ASSEMBLY** (If you have already sent one recently an update would be enough). This is primarily for the news brief and website.

iii. **YOUR ONGOING PLANS FOR COMMUNICATING WITH COUNTRY LEVEL PHM MEMBERS IN YOUR REGION** (News brief, list server, e-groups). In a spirit of Decentralization, each National and regional circle must begin to identify local resources and use strategic opportunities of ongoing national and regional meetings, campaigns, initiatives to link the proactive PHM evolution in that area / region enhancing. (This is already taking place in many regions – East and Central Africa, USA, Latin America, India . But more should be done in other regions).

Note: PHM secretariat has been informing all the new PHM enthusiasts who wrote to the PHM secretariat through website or exchange or directly to contact their regional facilitator. Please let us know how this is working out.

B. EVOLVING FURTHER PROCESS/CLARITY IN SOME REGIONS:

We need some urgent clarity about the process in some regions

i. **CHINA:** Can some one contact Amity Foundation and or other groups and initiate a PHM process there?

ii. **SOUTH ASIA:**

- We have country level facilitators in Bangladesh, Nepal, Pakistan, Sri Lanka – but not yet in Bhutan, Maldives, Myanmar?

- Could we request one of these country level facilitators to be the South Asia level facilitator till a regional facilitator is elected

iii. **SOUTH – EAST ASIA:** We have country level facilitator only in Philippines and contacts in other countries. But PHM process needs clarity. CAN PREM (ACHAN) AND DELEN (PHILIPPINES), ALONG WITH EVELYN HONG (TWN) BEGIN TO DIALOGUE AND PLAN THE PROCESS MORE ACTIVELY IN THE REGION? Who else to be involved? CLAUDIO COULD HELP FROM VIETNAM.

iv. **NORTH AMERICA:** While USA has an evolving process with Hesperian / Doctors for Global Health, there is no news whatsoever from the Canadian Coalition for Health. CAN MARIA / SARAH SORT THIS OUT AND ENHANCE THE FACILITATION? Perhaps all three groups could share the responsibility of being regional facilitator in turns with Hesperian perhaps being for the next 6 months and so on.

v. **WEST AFRICA:** While WGNRR has suggested Elvira Beleoken as their contact in Cameroon to play this role, can we suggest others who could join the

process and support the mobilization in the region. Perhaps Pat Nickson (DRC) and others can help out.

vi. **EUROPE:** Has lots of enthusiastic individuals, NGOs and Networks and lots of PHM initiatives but country level facilitators need to be identified, since so many countries are part of the expanding European region. CAN PAM, DAVID AND OTHERS HELP CLARIFY THIS PROCESS FURTHER?

[ANY COMMENTS ON THE REGIONS AND THE COUNTRIES INCLUDED IN THE REGION (SEE APPENDIX B) ARE WELCOME].

II. INCREASING SUPPORTIVE ROLE OF THE NETWORKS

The representatives of the eight founding Networks have very important roles to play in strengthening the geographical circles and helping to identify contact points and facilitator as well as launch campaigns. Some like IPHC are already playing an active role, others should seriously upscale their involvement in PHM. Some like WGNRR and HAI-AP are beginning to do so. They could do more, others can also clarify their involvement. Some of the ways they could do so are:

a. The Network / organization must evolve a policy of participation in PHM with clarity – what are the different activities they will support? How will they support them? Can they introduce some PHM support into their own annual plans and budget estimates? Can they support certain regions etc?

b. All networks and funding organization can alert their own network members and involve them in PHM initiatives.

- Their newsletters, bulletins could report on PHM activities.
- Their annual meeting, national and international meetings could have sessions on PHM, PH charter or link their ongoing themes and concerns to PHM.
- They could support regional get together, meetings or national circles.
- They could link their websites to PHM website and vice-versa
- They could encourage their members to actively participate in building a broader PHM coalition in their country and their region
- They may encourage their members, especially those with long standing experience to become the contact points in countries and initiate a process of networking and dialogue till a PHM facilitator evolves.

[ALL NETWORK REPRESENTATIVES ARE REQUESTED TO DISUCSS THIS WITH THEIR OWN BOARDS AND MEMBERS AND CLARIFY THE SUPPORTIVE ROLES, ISSUES, ACTIVITIES, THEY WOULD LIKE TO SUPPORT].

III. PROMOTION OF ISSUE BASED CIRCLES

As of date the WHO/WHA circle has been very proactive and the WHA events have been evolved through several communications and feedback systems (see last communication from WHA – June 2003).

There are at least 7 other issue-based circles, which are supposed to be evolving their processes and methods of communication and objectives. Each of them has a convener nominated for the purpose.

Some of the following initiatives have been taken by the various issue circles / networks:

- The War conflicts / Disaster / violence and humanitarian action circle has been very active on the Iraq war and the Palestinian health crisis and the anti-war efforts including the boycott's of US / UK goods etc.

- The Poverty and AIDS circle was started in response to a dialogue opportunity with UNAIDS in May 2001. Details of follow up are expected.

- The Women's Access to Health Campaign was launched on 27th May with a preparation period of months before that and WGNRR will continue to report on the process and events and the campaign momentum.

- The Research circle is helping to coordinate PHM's dialogue and participation in Global Forums for Health Research (Forum 7 meeting, December 2003, Geneva) ; Also in Global Research conference (Mexico 2004) and supporting the evolution of the Global Health Equity Gauge Report (see separate communication that follows soon) – linkage with GEGA) and prepare evidence based background papers for some of the events in the next two years.

[WE REQUEST ALL THESE CONVENORS TO SEND A SHORT SUMMARY OF

- WHO ARE IN THE CIRCLE;
- WHAT HAS BEEN DONE SO FAR OR
- WHAT IS BEING PLANNED? (THIS WILL BE PUT ON THE EXCHANGE AND THE WEBSITE SO THAT THE CIRCLES CAN BECOME MORE ACTIVE, COLLECTIVE AND INTERACTIVE)
- WITH VARIOUS REGIONAL AND GLOBAL INITIATIVES EVOLVING THESE CIRLCES CAN ALSO FOCUS THEIR ACTIVITIES ON DEFINITIVE OUTPUTS (BACKGROUND PAPERS FOR THESE EVENTS) OR ORGANIZE WORKSHOPS AROUND THE THEMES THEIR CIRLCES ARE EXPLORING] (see later communications on WSF IV (Health Forum – III and PHA II)

SOME ARE VERY NEW AND SOME HAVE BEEN AROUND FOR SOME TIME. THE REPORTS EXPECTED WILL BE VARIED BASED ON THIS FACTOR. EVEN IF THE PROCESS HAS BEEN SLOW, CONVENORS CAN SUGGEST A FRAMEWORK OR STRATEGY OF THE ISSUE AND PROCESS

1. **RESEARCH CIRLE – DAVID SANDERS (lmartin@uwc.ac.za or dsanders@uwc.ac.za)**

2. **POVERTY AND AIDS CIRCLE – DOROTHY LOGIE** (DeLogie@aol.com)

3. **WAR / CONFLICTS / DISASTERS / VIOLENCE AND HUMANITARIAN ACTION CIRCLE – UNNIKRISHNAN/ROSALIE BERTELL** (unnikru@yahoo.com, Rosalie.bertell@verizon.net)

4. **WOMEN'S ACCESS TO HEALTH CIRCLE – WGNRR** (wahc@wgnrr.nl)

5. **MACROECONOMICS AND HEALTH CIRCLE – MIKE ROWSON (MEDACT)** (mikerowson@medact.org)

6. **PUBLIC PRIVATE PARTNERSHIPS – JOSE UTRERA (WEMOS)** (jose.utrera@wemos.nl)

The circles on Macroeconomics and Health and the Circle on Public Private partnership will work closely with the research circle.

IV. ALMA ATA ANNIVERSARY INITIATIVES

A. COUNTRY LEVEL MEETING / DIALOGUE

i. This year you have all been requested by earlier communication from the secretariat to organize/ facilitate country level Alma Ata Anniversary meetings exploring the situation analysis, the challenges and lessons of Health for All Policy and the Primary Health Care strategy at country level.

ii. ALL REGIONAL AND COUNTRY LEVEL FACILITATORS / CONTACT POINTS ARE REQUESTED TO KEEP SECRETARIAT / EXCHANGE AND WEBSITE INFORMED ABOUT THESE MEETINGS AND TO CIRCULATE LEARNING EXPERIENCES, HANDOUTS, BACKGROUND PAPERS AND PROCEEDINGS.

iii. IF THESE MEETINGS ARE BEING PLANNED IN THE NEXT SIX MONTHS-JULY – DECEMBER 2003, PLEASE INFORM SECRETARIAT SO THAT WE CAN SEND BACKGROUND PAPERS AND REPORTS FROM OTHER REGIONS / OR GLOBAL DOCUMENTS.

iv. AT PHM Geneva / NGO Forum for Health session at World Health Assembly in May, we heard reports from Sri Lanka, Bangladesh, Latin America, Alma Aty, Russia and other places. More reports are expected. Please alert us to all these meetings at whatever level.

B. PHM POSITION PAPER

A PHM position paper entitled "twenty five years of primary health care: lessons learned and proposals for revitalization" facilitated by David Sanders, IPHC/PHM – South Africa will be circulated shortly on Exchange / website (by 30th June) to be used as a background paper / discussion document for Alma Ata anniversary meetings. This has been discussed in PHM steering group meeting in GK-Savar, November 2002 and PHM

– WHA, May 2003 with a wide range of PHM members (see website for other background material as well)

ATTENTION: DAVID SANDERS

C. **THE MILLION FOR HEALTH FOR ALL SIGNATURE CAMPAIGN** It is progressing well but we need a much more concerted and collective effort if we wish to reach the Million Signature milestone before the end of the Alma Ata Anniversary year. A separate update by Unnikrishnan and friends who are coordinating / facilitating this campaign is eing sent. Also you must have received a promotional letter by Prasanna, PHM communications officer. Please do take some action and let us know about your efforts to get in more signatures

D. **PEOPLE'S HEALTH AWARDS** A small sub committee is being formed with five PHM members to list out some criteria for nomination for these awards. These will be circulated shortly to all of you so that you can all help to nominate a few people from your regions who may qualify for these PHM awards (citations).

A larger committee will join this group to make the final selections.

[ANY SUGGESTIONS OF PRIMARY HEALTH CARE PIONEERS OR OTHERS FOR THE COMMITTEE FOR SELECTION?]

E. **THE FILM – REVIVING THE DREAM** Due to shortage of funds and delays of receiving the commitments that had been made or offered – the film 'Reviving the Dream' being facilitated by Unnikrishnan and Sathya Sivaraman has now been staggered to a new time schedule.

We need the steering group support as follows:

1. **IF YOU KNOW ANY GROUP THAT WILL SUPPORT A FILM WITH A SPECIAL SOCIAL THEME OR A POTENTIAL DONOR, CONTACT UNNI FOR A PLAN OF THE FILM AND FOLLOW UP URGENTLY ON THE ISSUE.**

   ATTENTION: MARIA , MANOJ

2. **IF YOU HAVE ANY IDEAS ABOUT THE FILM OR WOULD LIKE TO OFFER OTHER CREATIVE FORMS OF SUPPORT LET US KNOW IMMEDIATELY.**

Thanks for your patience!!

Ravi Narayan
Coordinator, People's Health Movement Secretariat(global)
CHC-Bangalore

Communication III **July 4, 2003**

Dear Steering Group Members,

Greetings from People's Health Movement Secretariat (Global) at CHC, Bangalore!

As continuation of the earlier communication for planning PHM Steering – we send you the next three items for your response

I. ALMA ATA ANNIVERSARY CELEBRATIONS MEETING IN IRAN (POTENTIAL)

- The Islamic Republic of Iran which has been a pioneer in Primary Health Care ever since it was an enthusiastic signatory of Alma Ata Declaration has offered to host a Alma Ata Anniversary meeting in Teheran in the second week of September in collaboration with People's Health Movement.
- A small PHM subcommittee is evolving the program in coordination with them and includes Dr. Mohammed Ali Barzgar, Dr. Zafarullah Chowdhury, Dr. Prem John, Dr. Ghassan Hamdan, Dr. Hani Serag and Dr. Pam Zinkin and the PHM Secretariat.
- AN INITIAL SECOND DRAFT OF THE PROGRAMME IS BEING CIRCULATED FOR YOUR COMMENTS AND SUGGESTIONS (SEE APPENDIX D).The funding is being worked out by the government in coordination with EMRO and SEARO and other potential funders at rather short notice.
- ANY SUGGESTIONS /CONTACTS FOR AGENCIES INTERESTED IN THE EVENT / REGION ARE WELCOME URGETNLY.

In the light of the evolving initiatives and processes towards the next People's Health Assembly, the secretariat is also trying to position this meeting in two specific contexts.

[A. As a Steering Group meeting to make urgent collective discussions (ALL STEERING GROUP MEMBERS SHOULD CONFIRM URGENTLY WHETHER THEY CAN MAKE IT TO THE MEETING].

- CAN THEY RAISE THEIR OWN FUNDS AS ADVANCE?
- OR ATTEND ONLY IF FUNDS FOR TRAVEL ARE AVAILABLE?

(This special request is only because the funding process is taking a little time. The Iran government will meet / reimburse all the local expenses]

- The Anniversary meeting will be 2 and half days extended by two days for steering group members only. The programme has included many steering group members to enable this to happen.

B. The event will also be a potential mobilization for PHM contacts in Middle East. If we can raise some resources (this is still very tentative) we hope that some participants from Africa region may also attend.

[CAN OUR PHM REGIONAL CONTACTS IN THESE REGIONS ADVISE US ON WHOM TO INCLUDE? SOURCES OF FUNDS, IF ANY? CAN ANY OF THEM SUPPORT THEMSELVES OR OTHERS?]

II. HEALTH FORUM AT WORLD SOCIAL FORUM- MUMBAI, JANUARY 2004

It was suggested that since the World Social Forum is moving to India in January 2004, a two day Health Forum would be arranged on 14th and 15th January 2004.

- At PHM Geneva, it was discussed that this could be the III International forum for Defense of People's Health which has now become an annual event linked to the WSF event. The last forum had a strong PHM presence This forum would also become the Asian regional focus preparatory meeting / consultant / assembly before the next People's Health Assembly.

- PHM India is on the Organizing Committee of this event and Amit Sengupta, Joint Convenor of PHM India, will circulate soon an updated draft idea of the event.

- A four member core group consisting of Amit, Maria, Armando and Mwajuma was formed in Geneva to look at the initial framework of both these meetings (WSF and PHA – II) since they could be strategic opportunity to build the process towards PHA-II.

    - PLEASE SEND HIM YOUR SUGGESTIONS TO THE IDEA DRAFT WHEN IT IS RECEIVED. MARK A COPY TO THE PHM SECRETARIAT.

    - HOW WILL EACH OF YOU ON THE STEERING GROUP PLAN TO MOBILIZE FOR THIS EVENT IN YOUR REGION AND WITH COUNTRY FOCAL POINTS IN YOUR REGION?

    - DO YOU HAVE ANY IDEAS FOR MOBILIZATION AND FUND RAISING FOR THIS ASSEMBLY?

    - WOULD YOU LIKE TO VOLUNTEER TO HELP THE PLANNING / MOBILIZATION / FUNDING OF THE ASSEMBLY.

    - WOULD YOU LIKE TO SUGGEST ANY ONE ELSE IN YOUR REGION WHO COULD HELP WITH PLANNING / MOBILIZATION / FUNDING OF THE ASSEMBLY

    (Send names after consulting them).

    [The Jana Swasthya Abhiyan (PHM – India) is meeting in Bangalore on 26th / 27th July 2003. We may also have some South Asian Steering Group members with us at this meeting. Please send all your suggestions on the Health Forum at WSF – IV by then, since it will be on the agenda of the meeting].

III. PEOPLE'S HEALTH ASSEMBLY – II (PORTO ALEGRE, JULY 2004)

The next People's Health Assembly has been announced after a collective opinion poll at the time of the health forum before the World Social Forum in Porto Allegre in January 2003 and also after a more detailed discussion at PHM Geneva in May 2003.

A four member core group including Maria, Amit, Armanda and Mwajuma evolved a draft idea framework for this next assembly (see APPENDIX E).

- PLEASE SEND THEM YOUR SUGGESTIONS TO THIS IDEA DRAFT IMMEDIATELY. MARK A COPY TO THE SECRETARIAT.

- HOW WILL EACH OF YOU ON THE STEERING GROUP PLAN TO MOBILIZE FOR THIS EVENT IN YOUR REGION AND WITH COUNTRY FOCAL POINTS IN YOUR REGION?

- DO YOU HAVE ANY IDEAS FOR MOBILIZATION AND FUND RAISING FOR THIS ASSEMBLY?

- WOULD YOU LIKE TO VOLUNTEER TO HELP THE PLANNING / MOBILIZATION / FUNDING OF THE ASSEMBLY?

- WOULD YOU LIKE TO SUGGEST ANY ONE ELSE IN YOUR REGION WHO COULD HELP WITH PLANNING / MOBIIZATION / FUNDING OF THE ASSEMBLY ?

(Send names after consulting them)

ATTENTION

[To help build greater focus, direction and framework for both these events we suggest that the following steering group members join the group as follows:

- Health Forum at World Social Forum - Zafarullah, Qasem, Prem, Bala, Delen, Evelyn, Ekbal, Mira, Carmelita, UPMRC.

- **PHA – II** – David, Melina, Pam, Olle, Hugo, Arturo, David Woodward, Fran Baum, Sarah, Andrew. Have I left anyone out?].

Thanks for your Patience.

To ensure that you do not get overwhelmed by this communication.

We plan to send you the next communication with the remaining items next week.

This will include:

VIII. Report from the PHM Evaluation group (coordinated by Andrew Chetely) that will be ready by the middle of July hopefully.

IX. A strategy and process paper from a PHM – GEGA / MEDACT Joint initiative on the Global Health Equity Watch Report which will become an evidence based background document for the next PHA – II.

[David McCoy and Mike Rowson have been working on the project and will report to the Steering group soon].

X. A communication strategy for PHM and how you all can support it as steering group members (this is being evolved initially by all those who have already shared the burden of communication responsibility in the PHM and includes Andrew and Nand (Website); Claudio (Exchange); Qasem and Prem (News brief); Unni and Sathya (Media releases); Pam (publications and charter) and Hani Serag – the latest volunteer to the communication circle.

XI. A report from the funding group to elicit ideas from all of you on funding sources and funding campaign ideas.

(A seven member funding group consisting of Andy, Olle, Maria, Prem, Qasem and Bala had already been supporting the Secretariat in this task. We am currently working on a 3 year project plan and logical framework, which will be shared with them next week and we shall then get back to you with ideas and suggestions. Manoj (Geneva), Sunil (Italy) and Sarah (USA) have also been invited to support this group since they have already been quite active in helping us in the last few months).

Please do acknowledge all these communications and send us your responses as soon as possible. Thanking you in anticipation.

Best wishes,

Ravi Narayan

Coordinator, People's Health Movement
Secretariat(global)
CHC-Bangalore
#367 "Srinivasa Nilaya"
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Bangalore-560034

Prasanna

Communication Officer
People's Health Movement
Secretariat (global)

APPENDIX D

Alma Ata Anniversary International Meeting
Islamic Republic of Iran in collaboration with PHM

International People's Health Movement

Regional Meeting

This note is a further update of
The Preliminary Note submitted to
The Hon. Minister for Health
Islamic Republic of Iran in Geneva, May 2003.

For His kind Information, Help and Action

By

The Coordinator
People's Health Movement, Secretariat
Through
Dr. Md. Barzgar, PHM, Iran

July 2003
PHM Secretariat (Global),
Bangalore - INDIA

Key Goals

- **Endorsing Health for All is Possible and Necessary**

- **Promoting the Struggle for the universal and Equitable Right to Health**

- **Enhancing Globalisation of Solidarity for Health for All**

'Health for All' is an Essential Human Need
- Primary Health Care is:
- A right of citizenship
- A duty of state
- The responsibility of society and
- A public good

People's Health in People's Hands

1. Perspectives:

People's Health Movement (PHM) took root in December 2000 in Savar, Bangladesh, where 94 people from 92 countries of the world met. There were health workers from grass roots rural communities, physicians, academics and activists from various disciplines, practitioners of public health and decision-makers. The primary objective was to "hear the unheard". This task was successfully accomplished as evidenced by the People's Charter of Health (PCH), a comprehensive document of hope, aspirations, dreams, definitive goals and most of all a call for action that would make health a reality for the millions of dispossessed and disadvantaged in all parts of the world.

2. The Present Plan:

The steering group of PHM with representatives from almost all regions of the world, met in November 2002 in Dhaka. Among other things, the Group resolved to mark the 25th Anniversary of Alma Ata. The Alma Ata Declaration was a radical departure from conventional decision-making in health and promised a more equitable and participatory paradigm of health planning and health care delivery in which people would have the primary role. Unfortunately, twenty five years later, the path is strewn with broken promises, the goals are nowhere near achievement and the old paradigm continues to reign supreme. The result is that in numerous countries of the third world, vital health indices either remain the same or have even deteriorated. Health

Care delivery systems are in shambles, access of the poor to meaningful health care severely limited and the poor continue to die in large numbers.

This situation is compounded by the implementation of neo-liberal economic policies of the rich countries, structural adjustment programs of the World Bank and International Monetary Fund, which have impoverished many southern countries. Most countries have ended up with the loss of their sovereignty, unable to make policies in favour of their own poor. Reduction or removal of subsidies,especially in public health, has resulted in favour of their own poor. Reduction or removal of subsidies, especially in public health, has resulted in denial of access of the poor to even the most basic of health care services. Reduction and removal of subsidies in the public distribution systems has brought about wide spread hunger, severe malnutrition, especially among children and even starvation in some parts of the world.

PHM recognizes the lessons that history has shown and believes that health can be achieved only if people's health is in people's hands. This can only be brought about if solidarity is built up among those most affected. To this end PHM, among other activities, will bring together people at national, regional and international levels to reiterate the principles first enunciated at Alma Ata and to pressurize theie ruling structures into implement these principles and practices so that Health for All may be achieved at least in the next ten to fifteen years.

However in some countries of the world including many in Latin America, also Iran, Tanzania, Uganda, Mauritius and some states in India and others, Primary Health Care had been taken up seriously sustained, strengthened, renewed and the spirit and perspective have been maintained in spite of global trends. PHM would like to focus on these countries, learn from their experiences and involve them in building a larger and stronger coalition in the struggle for 'Health for All'.

3. Immediate Plans:

Three big international and regional events will focus attention on the crisis in Health and Challenges of Health for All and will be facilitated by PHM between September 2003 and July 2004.

These are:

- Alma Ata Anniversary conference to mark the 25th Anniversary of Alma Ata, to be held in Teheran, Islamic Republic of Iran, September 9-12, 2003-05-22 (Republic of Iran and PHM as collaborators).
- III International Forum for Defense of People's Health (also Asian PHM Conference) Dialogue, 14-15 January 2004, preceding the World Social Forum in Bombay, India
- ALAMES, Peru (Latin American PHM Dialogue)

- Finally, the Second People's health Assembly 2004, July 3-7, 2004, Porto Allegre – Brazil.

4. The Teheran Event:

Objectives

- To mark the 25th Anniversary of Alma Ata, its promises and failures
- To look at the alternative models for inspiration and action through government and non-government efforts from all over the world.
- To highlight successful examples of PHC in the Islamic Republic of Iran
- To look at some issues of concerns and obstacles to Primary Health Care.
- To build contacts between people, build solidarity and to move the PHM forward (by building coalitions of all those who believe in PHC)
- To set an agenda for the future of this coalition.

Duration:	3 Days, (between 12-22nd September) This will include one day for field visits
Venue:	Teheran, Islamic republic of Iran
Accommodation:	As arranged by the local organizing committee in consultation with the Ministry of Health
Participants:	50 PHM representatives 50 - 100 Health decision-makers from countries and international agencies such as WHO as well as Ministers of Health and Directors-General of Health from the Middle East and SEARO areas 150 participants from Iran – grass roots health workers, practitioners, sensitive academics, health activists, and provincial and local health decision makers In total around 200 – 300 participants (could be less)

Methods:

1. Plenary sessions with few keynote presentation
2. Panel discussions with Panelists
3. Concurrent workshops – 5 to 6 days x 2 = 10-12 themes
4. exhibitions and Stalls and posters – (allowing for small corridor meetings around issues and experiences)
5. People's Theater highlighting health deficiencies and needs (songs, folk theater, creative initiatives from ongoing health campaigns)

Content Areas for Plenaries / Panel discussion:

- Primary Health Care - Strengths / Weaknesses / Opportunities / Threats
- Country and Region-wise examination of the links between poverty and health (impact on Primary Health Care)
- WTO, TRIPS and their impact on Health of the People and Primary Health Care
- Neo-liberal health policies including privatization /
- Primary Health Care experience – Health System / Health Policy

Workshops / Small Group Discussions:

2 - Trade issues
2 - Equity in Health
1 - Women's Health in Primary Health Care
1 - Human resources Development and the Primary Health / Health system
1 - Food security and Health
2 - Substance Abuse and Health
1 - War, Violence, injury and Health
1 – Environmental/Political and Health
1 - Mental Health and Primary Health Care
1 - Disabled and Primary Health Care
2 – Alternative systems of Medicine and PHC
2 – Public Private Partnerships and the PHC
2 – Community Health Financing and Primary Health Care
2 – Health Research in Primary Health Care

(These are suggested topics. Extra topics will be decided in consultation with the MoH and PHM constituencies and finalized by the Organizing committee)

Field Visits:

Will be limited to one day and participants will go in groups to visit nearby examples of successful health delivery programs north and west of Teheran as well as areas in Teheran where poor people live

Tentative summary budget:

The Ministry of Health, Islamic Republic of Iran through the Hon. Minister of Health have kindly agreed to bear the cost of accommodation, food and local travel of all the participants.

Travel: (Supported to some of the participants)

100 participants at US $ 750 per head	75,000	(25 PHM)
50 participants at US $ 1500 per head	75,000	(25 PHM)

Total Travel costs US$ 150,000

This could be borne by EMRO / SEARO / WHO and other funding agencies and also partly by PHM and its networks.

Tentative Draft Programme

	Am	pm
Day One	**Plenary / Panel** *Inauguration:* • Primary Health Care Experience (SWOT) • Poverty and Health	**Workshops** • Women's Health in Primary Health Care • Human resources Development and the Primary Health / Health system • Food security and Health • War, Violence, injury and Health • Environmental/Political and Health • Mental Health and Primary Health Care • Disabled and Primary Health Care
Day Two	**Plenary and Panel** WTO / TRIPS and impact on Health Privatization and Health Care	**Workshops** • Trade issues • Equity in Health • Substance Abuse and Health • Alternative systems of Medicine and PHC • Public Private Partnerships and the PHC • Community Health Financing and Primary Health Care • Health Research in Primary Health Care

Day Three	Field Work	Delegates Leave

Day Four & Five: PHM Steering Group Meeting (Only Steering group – Intensive Planning Discussion

Organizing Adviser, Iran: Dr. Mohamed Ali Barzgar, Health Adviser to Government of Iran and PHM – Iran Facilitator.

PHM Support Group for Conference:
Dr. Zafarullah Chowdhury (Bangladesh); Dr. Prem John (India); Dr. Pam Zinkin (UK); Dr. Ghassan Hamdan (Palestine); Dr. Hani Serag (Egypt); Dr. Ravi Narayan (PHM Secretariat, Coordinator)

APPENDIX E

III International Forum for Defence of People's Health
Bombay – India
From the 14th to the 15th of January 2004
Leading to
I World Health Social Forum
II People's Health Assembly
Porto Allegre – Brasil
From the 3rd to the 7th of July 2004

Methodology of the Event

- Presentations of all themes considering the word of the specialists and scholars and the living visions of the people – testimonies
- Build a strong analytical framework in order to generate a solid basis for the generation of strong proposals of action ordered in a political agenda for the next four years 2004 – 2008
- Be very careful with the mechanisms to establish a strong process of communication and empowerment of groups to achieve the goals established in the assembly
- Reinforce the regional organizations of PHM, widening the coalition of organizations articulated with the process of the Assembly and with PHM as a movement

Major Question

- The Struggle for the Universal and Equitable Right to Health and the Globalization of Solidarity
- Health for All is possible and necessary
- Health as an essential human need, a right of citizenship, a duty of the state, responsibility of the society and a public good

Main Themes

- Health as a human right and the legal expressions of it
- Trade issues and health
- Environmental destruction and health
- Militarism, conflicts and health
- Right to access Science and technology and its advancements
- Equity as a main goal
- State and Health reforms and the right to health and PHC and health promotion in the context
- Human resources for universal health systems
- The economics of universal health system

- Macroeconomic issues, poverty and health
- Women and children rights

Regional Approach

- 13 regions must evolve processes of dialogue on theme and representative participation leading up to the Second People's Health Assembly

Some Thematic subjects for Workshop

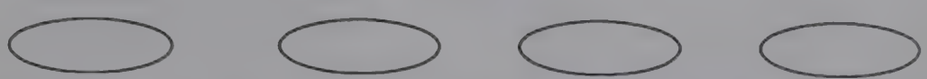
- Food security
- HIV/AIDS
- Water and Sanitation
- Drugs access
- Drug and substances, addictions and mental health – as social economic issue
- Mother and child care
- Endemics
- Chronic and degenerative diseases
- Injuries and violence

(Many more can be added)

World reality analysis and building of a position and an identity in the process to achieve the Right to Health for All

Regional Approaches to the Analysis, Positions and identities

Regional Themes



Thematic subjects Analysis, Positions and Identities in the regional scenarios and according Main Themes, Discussions and Conclusions

Thematic proposals according to Regions and Macro Issues

Regional proposals considering thematic challenges and macro issues coherence

Proposals to build new approaches for the main themes, considering new concepts, methodologies and organization to build a world with universal and equitable right to health

Organizational Structure

- Core group – **International committee**
  - Maria, Amit, Mwajuma, Aramando…(to involve PHM Steering group and expand with regional nominations and volunteers)
  - Committee will gradually divide into sub-groups focusing on PHA – II organizational issues including:
    - Contents / program
    - Mobilization as a process
    - Finances
    - Monitoring and evaluation of process
    - Local Logistics

- National and / or Regional Committees or Focal persons with the corresponding areas involving PHM Steering group members.
- Responsible persons for the development of the main themes and thematic subjects
- Local organizing committees in Bombay and in Porto Allegre

Associated Events – Preparatory Pathway

- Middle East activity July 2003 (UPMRC)
- Alma Ata Anniversary – Sept. 2003 - Iran
- World Social Forum – Jan 2004, Mumbai, India
- ALAMES congress – Peru – March 2004
- Next PHA –II – July 3-7 2004, Porto Allegre, Brazil

– – –

1.
2.

Dear PHM Steering Committee,

At the World Health Assembly, the Peoples Health Movement endorsed an idea put forward by GEGA and Medact to produce an "alternative world health report". After some weeks of discussion by a small group of individuals representing the organisation we have developed a concept note that we want to use to begin a process of wider consultation with other NGOs and with funders.

I am attaching the concept note and I would value your input and thoughts. In particular I would value any suggestions about people who would be able to contribute either as chapter authors, or as chapter reviewers. We are looking for two types of authors – authors who will be able to provide a rigorous and evidence-based analysis of the themes and topics; and secondly, authors who will be able to provide case studies and be expressions of the 'voices of the unheard' (these will be 'boxes' embedded within the various chapters as outlined at the present moment).

We are looking for the chapters to be co-authored by more than one author with the intention of reflecting as much progressive consensus as possible, and with the intention of ensuring that the authors do not reflect a northern bias. Therefore individuals, academics and NGOs from the South who you feel have some expertise that could contribute to a particular chapter would be especially welcome.

The chapters in Section C of the report relate to issues that are mainly outside of the health sector, and we are therefore looking for suggestions of people and NGOs who are working on issues related to the environment, agriculture, food security, gender etc.

I am hoping to have a list of authors and co-authors by mid-September.

I look forward to hearing from you

Thankyou very much

Dave (McCoy)

Dr David McCoy
DavidMcCoy@medact.org
(GHEW Coordinator)

People's Health Movement

GEGA
Global Equity Gauge Alliance

MedAct

Introducing the Global Health Equity Watch – an alternative World Health Report for the future

Background

Every day 30,000 children die of preventable causes. The HIV/AIDS epidemic continues to escalate, with the situation in sub-Saharan Africa already tragic, and large parts of Asia about to follow suit. Worldwide, poverty at the country, local and household level remains the biggest underlying cause of morbidity and premature death. 1.2 billion people, mostly women and children, live on less than US$1 a day[1].

Added to this are ever-growing inequities. The poor are getting poorer, and the sick are getting sicker and dying earlier; the healthy are getting healthier, and the rich are living longer and consuming more. The world's 25 richest people have income and assets worth US$474 billion - more than the entire GNP of Sub-Saharan Africa[2].

In spite of the economic growth and technological advances of the last forty years, and the fact that some countries, notably the asian tiger economies, have managed to demonstrate remarkable rates of development, for millions of people, standards of living have not improved. Worst still, the social and economic development of some has come at the cost of the impoverishment of others.

The resounding failure of the global community to achieve "Health for All by the Year 2000" has been met with barely a whimper (apart from the efforts of the Peoples Health Movement to revitalise the Alma Ata Declaration with a Peoples' Health Charter).

Meanwhile the global health institutions of the UN system have become increasingly weak. The World Health Organisation, for example, has become an increasingly small player on the global health and development policy stage which is dominated by the World Bank. Even the World Trade Organisation and the International Monetary Fund have potentially become more

[1] African Poverty at the Millennium, World Bank, Washington DC, 2001.
[2] Data from Forbes, GNP of Sub-Saharan Africa was US$315 billion in 1999.

significant health policy players by virtue of the impacts of trade policies and broader public sector policies on health and health care.

The Alma Ata declaration which enshrined the principles of equity, social medicine, appropriate technology, access to comprehensive health care and sound public health approaches to disease prevention and management, has virtually disappeared from the WHO agenda, and when it does reappear, it is apparent that the conceptual meaning of the "PHC Approach" is no longer understood by WHO, who frequently confuses it with primary level care. Instead, WHO has become increasingly tied up with vertical disease-based approaches and questionable econometric, number-crunching exercises. Others have pointed to its support of the flawed analysis and recommendations of the Commission on Macro-economics and Health, and the increasing influence of the corporate and private sector.

The World Bank on the other hand has continued to foist discredited, neo-liberal solutions to global development and poverty alleviation. Rather than supporting the development of public health systems, they have promoted the fragmentation of health systems and increasing privatisation. Health sector liberalisation with an increasingly under-funded public sector safety-net for the poor remains the stock solution – in spite of its glaring failures. On top of this, market-based reforms of the public sector are offered as solutions to the bureaucratic inefficiencies that result from demoralised, under-skilled and under-paid civil servants.

Year after year, the world is treated to a new set of commitments, goals and targets for development and health – the latest being the millennium development goals. While making grand pronouncements on debt relief, trade reform, aid and HIV/AIDS, the truth is that overseas development assistance has declined, whilst the trade and investment environment have become even more unfriendly to poor countries. The commercial imperatives of rich-country companies and multi-national corporations have consistently taken precedence over social development, poverty alleviation, equity and economic fairness.

Although conflict, corruption, inefficient, unethical and undemocratic government within many countries are a hinderance to equitable development that requires local action, the establishment of such governments often have external global contributory and causal factors.

In response to the situation described above, more and more health workers realise that the principles of the Alma Ata Declaration no longer guide health sector development. More and more communities and academics are aware of how the international economic system and globalisation is perpetuating poverty and increasing inequities; and the lack of credible and effective global public health leadership has become increasingly evident.

In response to this situation, the Peoples Health Movement, together with Medact and the Global Equity gauge Alliance, have proposed the development on an alternative World Health Report (to be known as the Global Health Equity Watch).

WHO produces an annual health report, and other UN agencies such as UNICEF and UNAIDS produce regular world reports on particular health topics. The World Bank produces a World Development Report once every two years and the UNDP produce an authoritative Human development report every year. In addition, academics and NGOs produce many documents describing and discussing the state of global health. How would the Global Health Equity Watch add value to this existing body of literature? What would be the characteristics and values of an 'alternative world health report' that would make an alternative world health report worth

investing in? The following section describes the purpose, characteristics and need for an alternative world health report.

2. Purpose, characteristics and need for an alternative world health report.

The Global Health Equity Watch would represent an 'alternative world health report' that:

- Places equity and not poverty at the centre of its analysis - this stands in contrast to the more common emphasis on targeting the poor and the marginalised without relating them to the rich and powerful. We believe that any significant improvement in the health of the poor and the marginalised will only be possible through an explicit commitment to reducing the gaps and disparities between the rich and the poor; and between the powerful and the marginalised.

- Amplifies the 'voices of the unheard' - this stands in contrast to reports that are produced using technocratic language and inaccessible formats. We want to produce a report that is accessible, grounded in reality and which reflects the voices of the poor and the marginalised.

- Provides a non-neoliberal perspective - this stands in contrast to the dominant development discourse amongst the multi-lateral development agencies and OECD countries. We believe that governments and the public sector have a social obligation *and* are able to provide basic social services in way that promotes equity and ensures effectiveness and efficiency. The gradual dismantling of the state has led to greater inequities, and we seek to promote policies that will support the establishment of public sector bureaucracies that work effectively and efficiently, rather than diminishing their role.

- Promotes the PHC Approach - we believe that the principles of the 1978 Alma Ata Declaration remain relevant, credible and sound. The Global Health Equity Watch will work towards explaining the on-going meaning, relevance and importance of these principles.

- Promotes health systems development in contrast to vertical, disease-based interventions - in recent years, there has been a growing tendency to address certain particular diseases rather than addressing the core fundamental components of functional health care systems.

- Places health squarely within a broader political economy perspective - this stands in contrast to the tendency for global health problems to be described in isolation of the unfairness of the global political economy. We believe that the politics and economics of health should be a central public health priority of all health workers concerned about the poor state of global health.

- Places health and the reduction of health inequities squarely within a multi-sectoral perspective - in addition to placing health and health inequities within the context of the political economy, the Global Health Equity Watch will promote a description of the links between health and other sectors such as the environment, international finance, agriculture and food security, war, housing, land rights, conflict and education. This will lead to a process of mutually beneficial learning, analytic integration and joint advocacy amongst different NGOs.

- Provides a civil society perspective to the state of global health - this stands in contrast to the publication of reports by UN and other multi-lateral institutions and also allows the performance of such institutions to be the subject of annual monitoring and reporting. In addition, the report will seek to express the views of people from the South.

- Links research and analysis to advocacy - the Global Health Equity Watch will do more than just describe the state of health and inequity. It will provide recommendations and encourage advocacy actions that will help ensure that real change in favour of justice and redistribution takes place and that governments and the relevant international institutions are held more accountable to those who are marginalised and impoverished.

While the report will primarily be an analytic and evidence-based document grounded with some descriptive elements of reality on the ground, it will also be explicitly based on a sound justification of the normative principles and values described above.

3. Management

The production of the report will be managed and coordinated by the three organisations listed above. They will be guided by an advisory technical committee. Because the three sponsoring organisations are mainly located within the health sector, they will develop partnerships with organisations from the non-health sectors to ensure that the report adequately reflects a multi-sectoral approach to health. Efforts will be made to make the process as inclusive as possible.

4. Structure and Lay-Out of the Report

The Global Health Equity Watch will consist of a compilation of chapters (some with discrete with sub-sections) on various global health issues, supplemented with testimonies from the ground and the voices of people who are traditionally unheard. The idea is not to commission new research. Many NGOs and academics have done the research and analysis for which the Global Health Equity Watch will provide a platform for further dissemination and popularisation. It will also provide an opportunity for the analysis to be complimented with "stories from the ground" and an advocacy agenda. Only in some instances will it be necessary to commission some primary research.

The idea is that the chapters would be written by an eclectic group of experts and NGOs, representative of all regions of the world. For each chapter, a lead author will be identified and asked to coordinate the inputs and perspectives from other experts in the field, representing as many regions of the world as possible. Each chapter will also have designated reviewers.

The approximate size of the report: 150,000 words.

The suggested structure and chapter headings of the report are shown in the following section:

Structure and Chapter Headings of the Global Health Equity Watch

FORWARD

INTRODUCTION

SECTION A: INTRODUCTION TO GLOBAL HEALTH INEQUITIES

A1: Health in a Divided World (Socio-economic, health and health systems inequities)

SECTION B: THE POLITICAL ECONOMY OF HEALTH, DEVELOPMENT POLICY AND HEALTH SYSTEMS

B1. The Politics and Economics of Poverty and Inequity – A Global Public Health Priority

B2. Failing Prescriptions - Social Sector Policy and Ideology

B3. Health Policy: The Privatisation Agenda

B4. Where are our doctors? The Global Brain Drain of Health Personnel

B5. Big Pharma and the Future of Accessible Medicines

B6. Global Public Health Leadership – Making it Visible, Effective and Progressive

SECTION C: BEYOND THE HEALTH SECTOR

C1. Agriculture and Food Security

C2. Water

C3. Militarism, War and Conflict

C4. Environment

C5. Gender and 'Women's Access to Reproductive Rights

SECTION D: MONITORING AND ADVOCACY SECTION

This section will consist of a number of sub-sections each of which will highlight a few key institutional case studies (we want a report that is monitoring the performance of key actors) and policy recommendations related to the earlier chapters. The purpose of these sub-sections will be to affirm the notion accountability to civil society, and at the same time inform the advocacy and lobbying actions of a global progressive health movement committed to a just world and health for all. There would be a number of sections, for example:

- Trade and WTO
- ODA
- HIPC initiative
- IMF
- Global political and economic governance
- WB Watch
- WHO and other international health agencies
- GATS and Health Watch
- Global medicines watch
- Global health research watch
- Donor watch

Compiled by David McCoy
July 2003
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TWENTY FIVE YEARS OF PRIMARY HEALTH CARE: LESSONS LEARNED AND PROPOSALS FOR REVITALISATION

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1. PRIMARY HEALTH CARE – FOCUS AND IMPLICATIONS

The strategy of Primary Health Care, advanced by WHO and UNICEF, was declared by 134 states at Alma Ata in 1978 to be the means to achieve Health for All (HFA) by the Year 2000[7]. PHC had strong sociopolitical implications. It explicitly outlined a strategy which would respond more equitably, appropriately and effectively to basic health care needs and also address the underlying social, economic and political causes of poor health. Certain principles were to underpin PHC, namely, universal accessibility and coverage on the basis of need; comprehensive care with the emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; intersectoral action for health; and appropriate technology and cost-effectiveness in relation to the available resources[8].

The implications of PHC were recognised, even at the time of the Alma Ata Declaration, to be far-reaching if the strategy were to be properly applied: the principles would have to be translated into changes not merely in the health sector but also in other social and economic sectors as well as in community structures and processes.

2. MIXED PROGRESS IN GLOBAL HEALTH

Over the past 50 years and even over the last 25 considerable gains in health status have been achieved. Globally, life expectancy at birth has increased from 46 years in the 1950s to approximately 65 years in 1995[1] and the total number of young children dying has been restricted to approximately 12 million instead of a projected 17.5 million[2]. Substantial control of certain communicable diseases, notably poliomyelitis, diphtheria, measles, onchocerciasis (river blindness) and dracunculiasis (Guinea worm) has been achieved through immunisation and specific disease control programmes[3]. and cardiovascular diseases have decreased in males in industrialised countries, partly because of a decline in smoking[4].

Despite these gains, however, there have been setbacks. Although in aggregate terms child mortality and life expectancy have improved in all regions of the world[5] disaggregation of these data reveals that the gap in mortality rates between rich and poor between and within countries has widened significantly for certain age groups. Furthermore, in a number of Sub-Saharan African (SSA) countries, infant mortality rates (IMR) actually increased in the 1980s under the impact of economic recession, structural adjustment, drought, wars and civil unrest and HIV/AIDS[6].

The past two decades have also witnessed the alarming resurgence and spread of old communicable diseases once thought to be well controlled e.g. cholera, tuberculosis, malaria, yellow fever, trypanosomiasis, dengue etc. while new epidemics, notably HIV/AIDS, threaten this century's health gains in many, mostly developing, countries. Many developing countries are also experiencing a double disease burden, with cardiovascular diseases, cancers, diabetes, other chronic conditions and violent trauma replacing communicable diseases in some social groups, but in others co-existing with them.

3. PROGRESS AND REVERSALS IN IMPLEMENTATION OF PHC

Implementation of PHC has been rendered difficult as a result of misinterpretation and of changed context. Misinterpretation was rooted even in the Alma Ata document wherein PHC was defined as both a "level of care" and an "approach": these two different meanings have persisted and perpetuated divergent perceptions and approaches. Thus, in some developed countries and sectors PHC often has been interpreted as primary medical care provided by general doctors, and in developing countries as a cheap, low technology option for poor people[9]. Even in countries which embraced PHC as the key to Health For All (HFA), conservative changes in the 1980s in the political and economic context bedevilled its implementation.

There have, however, been significant successes especially in the 1980s, in implementing PHC, although mainly in the development and extension of particular health programmes, rather than in the facilitation of social development though the promotion of an intersectoral approach and community participation[10].

The greatest successes in PHC implementation in developing countries have been in respect of its more medically-related elements. For example, in the 1980s coverage of growing children with the six basic vaccinations increased dramatically from below 40% worldwide to over 70% by 1990. Similarly, access to oral rehydration therapy (ORT) for treatment of diarrhoea expanded over the same decade as did improved access to water and sanitation in some parts of the world.

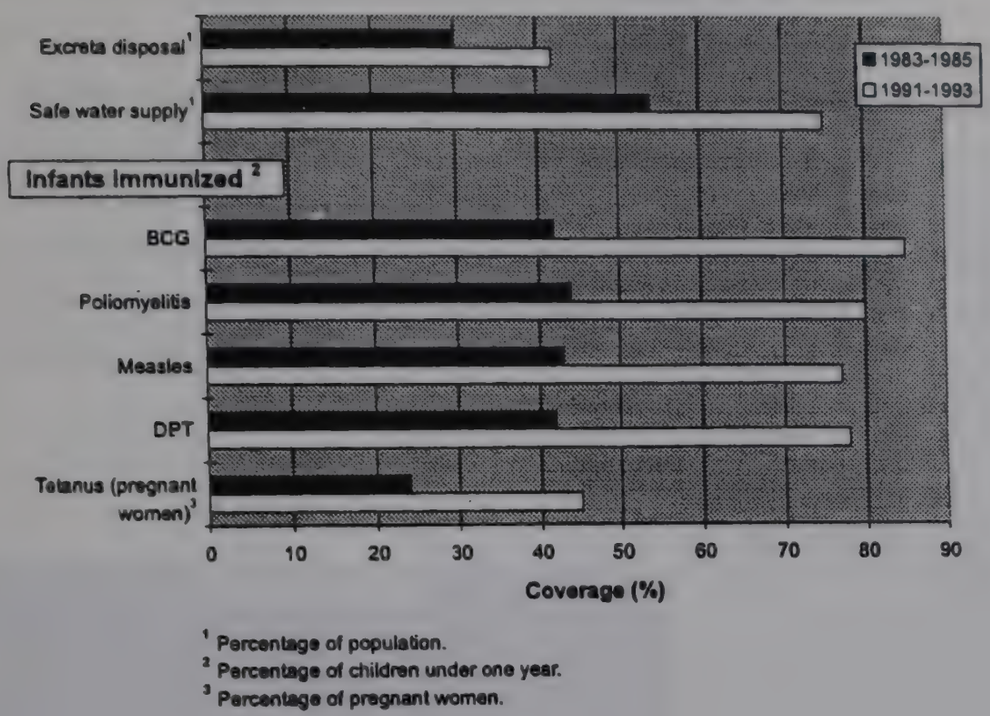
However, the control of both communicable and non-communicable diseases has proved elusive. In particular HIV/AIDS, T.B. and malaria are affecting rapidly increasing numbers of (especially poor) people worldwide. HIV, which now affects over 40 million people, three-quarters of them in sub-Saharan Africa (SSA), has led to declines in life expectancy in a number of countries. The control of these three diseases and of the chronic diseases, which affect increasingly large numbers of poor people, is complex and clearly requires improved living and working conditions, well-functioning health systems and strong intersectoral coordination and community mobilisation.

However, it is clear that health systems in most developing countries, and especially in SSA have deteriorated in the past ten to fifteen years. This is most starkly illustrated by the decline in vaccination coverage of young children to well below 1990 levels, despite intensive polio vaccination campaigns and the regular measles vaccination campaigns.

3.1 Progress and Setbacks in Implementing the Programme Elements

Since the early 1980's there has been considerable progress in the coverage of populations with the essential elements (or programmes) of health care.

Figure 1. **Access to selected elements of primary health care, developing countries, 1983-1985 and 1991-1993**

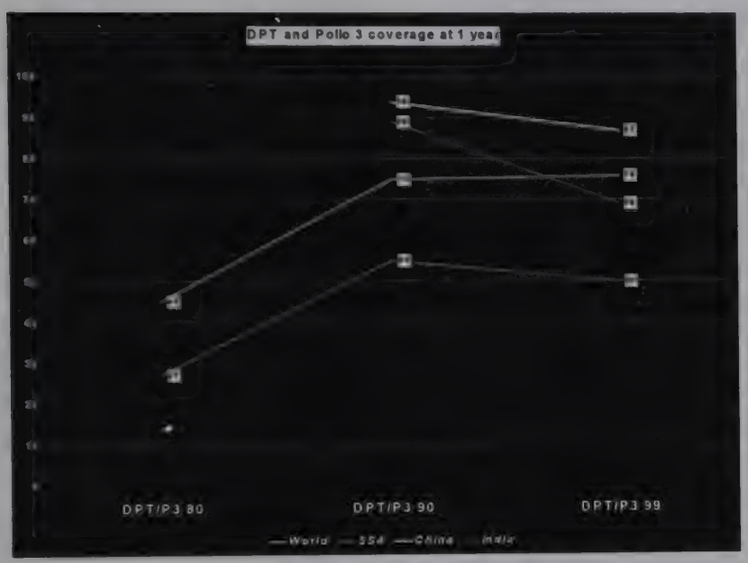


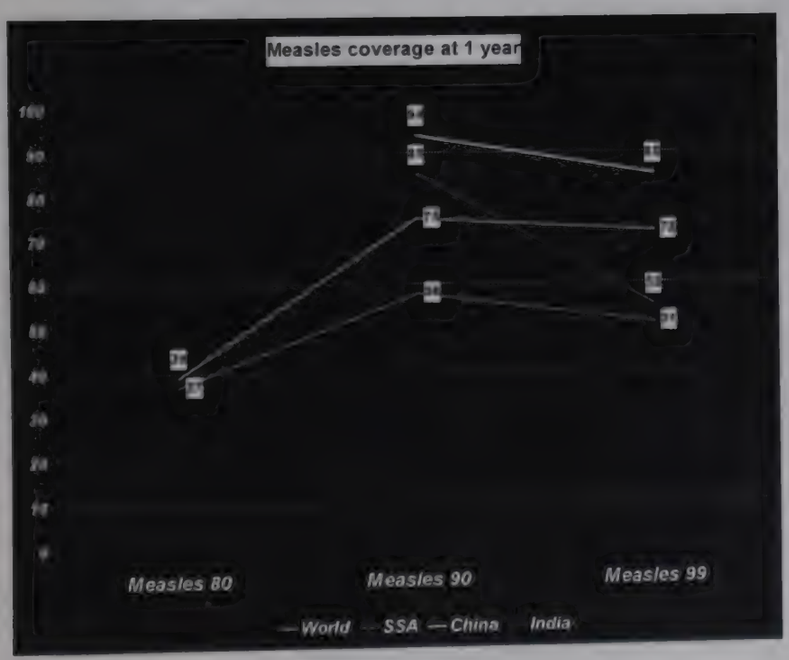
[1] Percentage of population.
[2] Percentage of children under one year.
[3] Percentage of pregnant women.

(Source: WHO 1998B, p 4)

There has been some progress in improving access to **water supply and sanitation**, although great differences continue to exist between and within countries and social groups.

Child health care provision has increased greatly over the past two decades with the vigorous promotion of certain selected "Child Survival" technologies: growth monitoring, oral rehydration therapy, breastfeeding and immunisation (GOBI). Of these, **immunisation** has shown the most dramatic improvement, with global coverage of children under one year increasing from 20%[11] in 1980 to 80% by 1990. This impressive progress notwithstanding, there remain areas for concern. These include stagnation in immunisation coverage between 1990 and 1993, and declines in coverage in most regions of the world by 1999[12] with the most difficult -to-reach population being the group experiencing a disproportionate burden of vaccine preventable disease; the reappearance of diphtheria in the Newly Independent States as a result of vaccine shortage and poor programme management[13]; and less than 50% coverage of pregnant women with tetanus toxoid vaccine.





The **nutrition situation** in developing countries remains serious with almost 200 million young children being malnourished and almost a billion people receiving less than their basic daily requirements of energy and protein.

Acute respiratory infection (ARI) and **diarrhoeal diseases** are the two leading causes of death in children under 5 globally with the overwhelming majority of cases occurring in developing countries. Standardised management guidelines have substantially reduced fatality rates but the impact has been less than anticipated due to interrupted and inaccessible supplies of oral rehydration solution, improper usage and an unabated high incidence of diarrhoea as a result of minimally improved environmental hygiene and persisting malnutrition[14]. More recently, given that 70% of young child deaths can be attributed to diarrhoea, pneumonia, measles, malaria and malnutrition, clinical guidelines for the **integrated management of childhood illness** (IMCI) have been developed[15].

Maternal health has received far less attention than child health, with levels of **maternal mortality and morbidity** from largely preventable causes in developing (particularly the least developed) countries remaining unacceptably high.

Table: Maternal Mortality Rate.

Country groupings	Maternal mortality per 100 000 Live births, 1991	Number of Member States Included, 1991
Developing countries	421	113
Of which least developed	*727*	*37*
Eastern Europe	41	8
Developed market economics	34	25
Total	**370**	**146**

(Source: Tarimo & Webster 1994, p 39)

Control of the three most common and serious **communicable diseases**, tuberculosis (TB), HIV/AIDS and malaria has proved elusive. TB is now responsible for over 25% of avoidable adult deaths worldwide[16] with 95% of cases occurring in developing countries; its prevalence has risen sharply over the past decade-and-a-half as a result of HIV infection, deteriorating socio-economic conditions and poor quality control programmes, together with the emergence of multi-drug resistant organisms. The HIV epidemic has spread rapidly to affect over 40 million individuals, mostly in developing countries, especially Sub-Saharan Africa (SSA), and involves predominantly young adults and children born to HIV-infected women. In some SSA countries gains in survival achieved over the past few decades are being reversed by the effects of HIV infection. The malaria situation remains serious, particularly in SSA where it imposes high mortality and morbidity levels and a major economic burden from lost productivity and escalating treatment costs as antimalarial drug resistance spreads.

Current strategies for control of these diseases are remarkably similar. TB control programmes rely heavily on directly observed short course chemotherapy (DOTS); HIV control has focused on targeted educational activities and early treatment of STDs; and malaria control on early diagnosis and treatment and selected preventive measures

particularly insecticide treatment of bednets - as part of WHO's new "roll back malaria" initiative. While the technologies employed in all three cases have evolved considerably in the past decade, sustained success in combating these diseases is unlikely without well-developed health systems, improved living and working environments secured through anti-poverty measures and coordination with health-related economic and social sectors, and active participation by communities in such control campaigns.

The major **non-communicable diseases** such as cardiovascular disease, cancers, diabetes and mental illness together with violence and injuries contribute significantly to the burden of disease in developed, and, increasingly, in developing countries. Their complex epidemiology requires better clinical management and lifestyle modification but also actions involving a range of sectors and tied to more fundamental measures, for sustainable impact.

Thus it is that the understanding and application of **health education**, one of the elements of PHC, has evolved significantly from a preoccupation with individual behaviour change towards a broader set of activities termed "health promotion", which incorporates individual as well as social action[17].

The final programme element to consider is **Essential Drugs**. While access to essential drugs is much improved approximately two billion people still do not have access to the most important drugs and vaccines[18] and at the same time drugs bills for most countries and their health services are massive, and problems of wastage and irrational drug use remain.

3.2 Progress and Setbacks in Health Systems Development

In the 1980s there was little recognition of the importance of health systems and almost a decade after Alma Ata the activities of various programmes and institutions continued largely to be piece-meal, poorly coordinated, and unevenly distributed. As a result, the concept of the district health system (DHS) was born[19].

The DHS has been promoted as the unit within which the implementation of primary health care by the health and health-related sectors (public and private), and communities can be best organised and coordinated. District management structures were envisaged as a focus for decentralisation of political power and resources, increased democracy and equity.

Despite efforts over the past ten years or more, there are few countries where district health systems are functioning fully and effectively[20]. There are a number of linked reasons for this: these are related ultimately to the lack of capacity – human and financial – of health services at local levels and an unfavourable broader political and economic environment.

In short, health systems development has been uneven and constrained by fiscal austerity, which has in many countries adversely affected the quantity and quality of human and material resources and logistical support. Efficiency imperatives which have spurred health sector reform and alternative financing approaches in both

industrialised and developing countries, have sometimes generated significant innovation but have also often aggravated dysfunctionality and inequity, particularly in developing country health systems[21].

Despite the fact that the successful functioning of health systems depends critically on adequate numbers and competence of personnel who account, in most countries, for approximately 70% of recurrent expenditure on health services, this important area has received inadequate attention in the HFA initiative.

Since 1978 there has been a considerable expansion in health human resources particularly at the "auxiliary" or "paramedical" level in developing countries and, especially in the immediate post-Alma Ata period, in the community health worker cadre. Despite this, many poor countries, especially the least developed, have too few health workers to provide universal coverage and in all countries there continues to be significant maldistribution of, and imbalances between, various types of health workers.

Teamwork is, on the whole, poorly developed[22] and the motivation and competencies of health personnel require considerable strengthening, especially in the non-clinical domains, to implement PHC. Also, greater involvement of traditional practitioners in the health system has been advocated in some countries: achievements in this regard have been limited, with the notable exceptions of China and India where progress largely antedated Alma Ata.

One of the most significant impediments to the successful implementation of PHC, and a major reason for the continued dominance of specialist and hospital-based health care in many countries, has been the substantial failure of most tertiary education health science institutions to adapt their missions and activities to the challenge posed by HFA. Primary health care and public health usually remain marginalised in the formal curriculum and, when present, are often presented in an abstract and theoretical form, with little application to priority health problems and challenges[23].

Further, the training of health professionals mainly at the secondary and tertiary levels of care has meant that health workers are ill-equipped to do primary level work. If health workers are to render comprehensive care at all levels, their practical and theoretical training must be relevant to addressing the needs of the population. It is urgent, therefore, that district-based health teams receive such training[24].

Additionally, important aspects of management of human resources, such as mechanisms to ensure greater retention and improved support and supervision, have been given insufficient attention. This has contributed to demoralisation and loss of personnel and inefficient and low quality service provision in the public health sector of many countries[25].

In summary, then, progress in implementation of PHC in developing countries has been greatest in respect of certain of its more medically-related elements (e.g. immunisation, oral rehydration therapy). This strategy of "selective primary health care" – symbolised in the 1980s by GOBI (Growth monitoring, oral rehydration therapy, breastfeeding and immunization) - has reinforced the "medical model" and de-emphasized equitable social and economic development, intersectoral collaboration, community participation and the need to establish sustainable and decentralised structures and systems. Thus, the mixed progress in global health reflects the uneven dissemination

of effective and robust health technologies, although often in a context of declining health systems, and in a situation of widening disparities in wealth and widespread poverty, resulting in diminished access for many to the basic needs of food, water, sanitation and housing. Acceleration of pre-existing economic, social and political interdependence has resulted in globalisation, characterised by such instruments of economic integration as Structural Adjustment Programmes and sweeping regulation of trade which threaten the economic sovereignty of poorer nations and in the short run have aggravated inequities[26] [27].

4. PROPOSALS FOR THE REVITALISATION OF PRIMARY HEALTH CARE

4.1 Equitable social investment

In charting the way forward in a world where wealth and health are becoming rapidly and increasingly polarised it is important to reaffirm the centrality of equitable, broad-based and gender-sensitive development and social sector investment in achieving substantial and durable health improvements. This is illustrated by the striking success that has been achieved in social development and health by a few poor countries, notably Sri Lanka, Costa Rica, Cuba, China and Kerala State in India. In these countries mortality and malnutrition rates are much lower and life expectancy much higher than in other countries of similar wealth and, indeed, many much richer countries. An authoritative study of these countries by the Rockefeller Foundation attributed their impressive achievements to a political commitment to equity, secured through strong movements of civil society or social revolution[28]. In all cases this resulted in the provision of universal education and an emphasis on primary health care, as well as the assurance of adequate diets through a combination of land reform and consumer food subsidies. That greater equity has been achieved and is associated with better social statistics, whatever the aggregate wealth of a country, is evidenced by the fact that these poor countries have much lower Gini coefficients (an index of relative equality) than neighbouring states.

4.2 Implementing healthy policies and comprehensive programmes

In synergy with equity-oriented social sector investment, a strategy to revitalise PHC requires the complementarity of "bottom-up" comprehensive health programme development and "top-down" policy development and planning. Successful implementation depends on the creation of a facilitatory environment through advocacy, community mobilisation, capacity-building and organisational change backed up by financing and legislation.

Policy development needs to involve those sectors, agencies and social groups critical to achieving better health. Steps include advocating health objectives as integral to socio-economic development, and engaging different sectoral partners and community structures in such a consensual process, which may benefit from setting agreed-upon goals and indicators of progress. Implementation requires functional intersectoral structures, and often laws as well as management instruments and equity-based financing[29].

PHC implementation has often been predominantly facility-based and focused on the curative and preventive components of comprehensive care, while the health promotion movement has stressed the broader social components. The divide between these two initiatives requires urgently to be bridged. Health promotion through Healthy Cities initiatives as well as a focus on other settings, including health districts, can advance the development of healthy policies[30]. The success of such multifaceted initiatives depends on organisational change within (especially) government and an openness to the positive potential of community groups.

Whereas health promotion activities commence with a multisectoral focus, programmes originating around diseases or health problems start from a health care response. By addressing priority health problems comprehensively through a combination of rehabilitative, curative, preventive and promotive actions a set of activities common to a number of health programmes will be developed as well as a horizontalised infrastructure. The principles of comprehensive programme development apply to all health problems.

Comprehensive Primary Health Care for some common diseases : a summary framework of priority interventions

DISEASE	INTERVENTION			
	Rehabilitative	Curative	Preventive	Promotive
Diarrhoea	Nutrition Rehabilitation	Oral rehydration Nutrition support	Education for personal and food hygiene Breastfeeding Measles Immunization	Water Sanitation Household Food Security Improved child Care
Pneumonia	Nutrition Rehabilitation	Chemotherapy	Immunisation	Nutrition Housing Clean Air
Measles	Nutrition Rehabilitation	Chemotherapy Nutrition Support	Immunisation	Nutrition Housing
Tuberculosis	Nutrition Rehabilitation	Chemotherapy Nutrition support	Immunization Contacts (tracing)	Nutrition Housing Ventilation
Cardiovascular Disease	Weight loss Graded exercise Stress control	Drug treatment Supportive therapy	Nutrition education Increased exercise Treat hypertension Smoking cessation	Nutrition policy Tobacco control Recreational facilities

Programme design should be based on an assessment of the seriousness of the problem, analysis of its multifaceted and multilevel causation and of the resources that can be mobilised to address it. Minimum or core service components such as the IMCI (Integrated Management of Childhood Illness) guidelines, protocols for clinical management of common diseases etc. should be integral to such comprehensive programmes and replicated at different levels of the health system, including in hospitals[31].

Such programmes need to be integrated into decentralised district systems. This inevitably requires transformation of both management systems and practice. A primary requirement is appropriate and usable health information for planning programmes and monitoring their implementation[32]. Where such information is lacking, health systems research – which may be fostered in working relationships with academic departments of public health – may assist decision-making[33].

Most district level health personnel will be based in sub-district facilities such as health centres and clinics. Health centres should be the focal point for comprehensive PHC : personnel teams will therefore need a combination of clinical skills and skills in participatory programme development[34]. Their success can be enhanced by working with and through community health workers: the role of this cadre needs to be re-examined, given their undoubted historical and potential contribution.

Since equity is core to the policy of HFA and current socio-economic and health sector trends are aggravating inequities, capacity to monitor equity in health and health care needs to be strengthened[35].

A prerequisite for the realisation of HFA is sufficient numbers and effective performance of health personnel in all phases of health systems development. The PHCA needs to strongly inform both curriculum content in all the health sciences as well as the process of, and choice of venues for, learning. Learners at undergraduate and postgraduate level need to be equipped with a broader range of competencies than hitherto has been the case[36]. Expansion of continuing education and training is urgent if system change is to be achieved in the near future. Relevance will be enhanced through problem-oriented and practice-based approaches, preferably involving multidisciplinary teams. To give effect to such changes, teaching staff in many countries also require urgent strengthening of knowledge and skills[37]. Retention of personnel in the public sector is increasingly difficult during the current economic crisis. Urgent attention needs to be given to implementing measures – incentives and regulations - to halt this loss from the public health sector of precious human resources[38].

5. CONCLUSIONS

It is clear that progress towards Health for All has been uneven. Gains already achieved are under threat from a complex and accelerating process of globalization and neoliberal economic policies which are impacting negatively on the livelihoods and health of an increasing percentage of the world's population and the large majority in developing countries. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programmes that have reduced substantially the impact of certain (mostly infectious) diseases, its intersectoral focus and social mobilizing roles – which are the keys to its sustainability – have been neglected, not only in the discourse but also in implementation.

In terms of implementation, the challenge is to revitalize Primary Health Care by drawing together the best of the PHC experience and the best of the HP initiative as well as important associated activities such as those around Local Agenda 21. Here the lessons learned in implementing Healthy Cities projects need to be applied more widely.

The time is long overdue for energetically translating policies into actions. The main actions should centre around the development of well managed and comprehensive programmes involving the health sector, other sectors and communities. The process needs to be structured into well-functioning district systems which require, in most countries, to be considerably strengthened, particularly at the household, community and primary levels. Here comprehensive health centres and their personnel should be a focus of effort and investment and the reinstatement of community health worker schemes should be seriously considered.

The successful development of decentralised health systems will require targeted investment in infrastructure, personnel and management and information systems. A key primary step is capacity development of district personnel through training and guided health systems research. Such human resource development must be practice-based and problem-oriented and draw upon, and simultaneously reorientate, educational institutions and professional bodies.

Clearly, the implementation and sustenance of comprehensive PHC requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sector in many countries. Here partnerships with NGOs and expertise in various aspects of community development is crucial. The engagement of communities in health development needs to be pursued with much more commitment and focus. Here the identification of well-functioning organs of civil society, whether or not they presently are active in the health sector, needs to be urgently pursued.

In promoting the above move from policy to action, WHO has to play a much bolder role in: advocating for equity and legislation to facilitate its achievement; pointing out the dangers to health of globalization and liberalisation; stressing the importance of partnerships between the health sector and other sectors; integrating its own internal structures and activities to ensure that comprehensive PHC programmes are developed; entering into partnerships with and influencing other multilateral and bilateral agencies and donors as well as non-governmental organisations and professional bodies towards a common vision of PHC; and arguing for major investment in health, especially in human resource development, without which HFA will remain a mere statement of intent.

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Tentative Framework

	Event Focus (From Secretariat)	**Regular**	**Reports - November 03**
June - August 2003 News Brief - 10	Alma-Ata Anniversary Meeting – Iran, September 2003	News from Secretariat, New Publications, (Million signature campaign), Upcoming events, News from Regions, (Women Health Campaign), WGNRR	• PHM Africa Tour (Mwajuma), • PHM – US tour (Sarah Shannon), • PHM Geneva event, May – (Extract from Report Circulated) • PHM statements at WHA – PHC; NGO recognition, TRIPS etc
September - November 2003 News Brief - 11	Health Forum – World Social Forum – January 2004 (pre PHA – II – Asia meeting) (Further)	AIFO Awards for PHM (October 2003), News from Secretariat, New Publications, (Million signature campaign), Upcoming events, News from Regions, (Women Health Campaign)	• PHM – GHEW Initiative – August 2003 (Dave McCoy), • PHM – Iran, Alma aTa Anniversary Meeting – September 2003 (Report), • PHM – Germany Meetings (Thelma and Zafar Mirza in coordination with Christine), • PHM input in Genetics Review (Germany), • Steering Committee – September 2003 (Iran)
December 2003 - February 2004 News Brief - 12	Next WHA – 2004, ALAMES – March 2004 (pre PHA – II America's Meeting)	News from Secretariat, New Publications, (Million signature campaign), Upcoming events, (Alma Ata Anniversary) News from Regions, (Women Health Campaign)	• WSF – Health Forum Report (Amit), • Report from Latin American meetings in Cuenca and Quito (October – November 2004) (Arturo), • GFHR – Forum 7 (Geneva, PHM inputs) – David

			Sanders
March - May 2004 News Brief - 13	People's Health Assembly, Porto Alegre, July 2004	News from Secretariat, New Publications, Upcoming events, News from Regions, (Women Health Campaign)	• Alma Ata Anniversary Film (announcement, Unni / Satya), • WHA – Geneva, May 2004 Strategy
June - August 2004 News Brief - 14	Post Porto Alegre – A plan of Action	News from Secretariat, New Publications, Upcoming events, News from Regions, (Women Health Campaign)	

DRAFT

Date: 25-07-2003

COMMUNICATION STRATEGY[1]

Background: The background to this paper is to prepare a draft communication strategy, which would help in the growth and sustenance of the movement and at the same time caters to the need to achieve the change.

The communication needs to act as stimulant, as information place, as a strategy, which helps in creation of ideas and thereby make more people get interested and involved. Also the communication methods used should be such that the message of PHM reaches to all the people who matter (both digitally enabled and marginalized). Also to promote communication as if people mattered for adopting health promotion and social action to the global imbalances of the 21st Century [3].

The following paper is discussed first based on the nine basic tools available with PHM at present - identifying their objectives, the time and context for each of these followed by some practical action plan for each of these individual tools and then a final note on the broader issues involved.

The nine basic tools identified are

1. Mass Media
2. Newsletter (Newsbrief)
3. Website
4. PHA Exchange (Email List server/ Discussion forum)
5. Charter and other Publications
6. Active Campaigns / word of mouth
7. Meetings / Workshops
8. Video
9. Performing Arts

1. Mass Media:

i) Objectives:

- To reach the general public (normally local) and not necessarily digitally enabled and not necessarily people who are working in the area of health
- To increase the awareness, visibility of the activities of PHM and also to convey the stand taken by PHM on the various issues (health, non-health).

- To increase the awareness of people on the macro determinants of health
- Getting new people/organizations/networks interested in the work of PHM and getting them into the PHM fold

ii) Possible Content:

- Content about PHM
- About current issues (health / non health) and content on macro factors like LPG, sanitation and environment etc.,
- About current events / campaigns
- Local news / issues

iii) Ways and means used:

- Press releases
- Media releases
- TV, films and documentaries
- Through cable channels and networks (Eg. The Science Channel coming up in India)

iv) Context (When and Where)

- Before, during and after an event
- If through cable, then anytime
- If TV, then in the local TV through films and documentaries (preferably just before an event in the local
- Of course, media releases can be in local, regional and International before during and after the event

v) The way to go ahead (Some practical aspects both short and long term)

- A journalist with PHM who would prepare a series of articles in local, regional and international media (quoting both PHM and non-PHM sources) written objectively as a build up to an event [2]

- Background / position papers to be prepared on a host of issues

- We could prepare copies of A-V aids and then the respective focal points must conduct events / meetings / avenues for the transmission of the same, but also ensure that it is translated (or at least a sub-title) is added to these. Also the information can be disseminated through local channels / cable-TV)

- As the target group is mostly local, non-health and not necessarily digitally connected, it must be made in such a way that it is more interactive and also in such a way that it sustains the interest of the general public.

- As this is a very powerful medium the local activity can be given more thrust than the international aspect of the movement

- Opportunities must be identified 1-2 months before an event happening in the region and a series of communications pushed through media and press releases to increase the visibility of PHM in the region and to help in the coming together of many more organizations

vi) Measurement Indicators:

- News coverage
- Building a response to an article
- Effectiveness
- Lessons learnt etc.,
- Also some form of feedback could be built into the system

2. Newsletter (Newsbrief)

i) Objectives:

- To reach the grassroots people who are digitally marginalized but not excluding the digital form and also to reach people who are not necessarily working exclusively in the area of health. Also targeted for PHM friends and decision makers

- To disseminate information about and the latest happenings in PHM

- To stimulate similar action in others regional circles / organizations/individuals of PHM

- To be made an interactive document to facilitate active reading

ii) Possible Content:

- Reporting about events/campaigns
- Information about upcoming events
- Latest international rules, guidelines issued by organizations like WHO, WTO etc.,

- Region-wise reporting than the present continent-wise (?)
- Background papers
- Contemporary issues

iii) Ways and means used:

- Paper form (and probably printed in local language and content). Also in a decentralized manner up to the regional facilitator so that information dissemination to the grassroots happens faster and also where necessary in local language and content.

- Digital form (to be put on the website as well!). To reach all the people who had expressed interest through the feedback form and also the ones subscribed on the PHA- Exchange

- Also through subscriptions

iv) Context (When and where)

- To be released periodically and also to utilize strategic opportunity of an event to release (probably a special issue). Could be released before or during an important meeting
- Archived on the website

v) The way to go ahead (Some practical aspects both short and long term)

- Since this is a very powerful source for reaching the grassroots, it has to be translated into the local language and then distributed (Long term).

- Just before an event, concentrating on the key issues handled /discussed (for eg. It could be a meeting to discuss drug and pharma issues) and putting up position papers on each of these[2]

- Put on the website with a clear set of action points[2]

- Urging people to use it as an instrument for lobbying in their respective regions/countries[3]

- The distribution has to be decentralized. Qasem / Prem/ Hani Serag / PHM Secretariat decide on the content and then the soft copy of the same is sent to the regional facilitator (mostly steering committee members) 15 days before the scheduled release and then translated. The translated version is printed and

distributed at the grass roots level. But since GK Savar has been identified as the main resource group for publications, one possible way is to send the translations back to GK (if the letters used for the local language is English (like most European languages like German, French and Dutch use English alphabets) for GK to print the same but if it is in other languages then some other ways of getting it printed (through transliterated software) from GK has to be thought of

- Newsbrief at present is done continent-wise (Asias, Americas etc.,), it can be done according to regional circles, with it acting like a stimulant for other regions which don't get covered in a particular issue of the Newsbrief, or alternatively the Newsbrief editors driving the regions to submit articles for this issue (maybe practically difficult)

- The Newsbrief could include the new countries that got added and the region which these countries belong to.

- The regional news could be prepared in the local language as well (with a gist provided in English) so that it gives an international flair to it (Long term).

- Event reporting and upcoming events columns

- Contemporary issues

- Making it interactive through such things like "quiz", subscriptions etc., and prompting people to respond to that and announcing the participants' name, country and region in a subsequent issue. We could also put some interactive questions like "Pakistan, A new country joined the South Asian region. Did any country join PHM in your region? If so, write back" types might prompt people to reply back.

- All this makes it imperative for the Newsbrief to become decentralized and also the activity for each issue starts at least **ONE** month in advance to enable completion of the regional coverage

vi) Measurement indicators:

- Has it been participatory with the involvement of the regions?
- Has it been interactive?
- Provision of feedback in the Newsbrief itself

- New organizations/ networks / individuals joining the movement and also taking up organization of campaigns based on the events reported etc.,

3. Website

i) Objectives:

- To reach mostly the digitally enabled, Decision makers, Lobbying circles, Health professionals, General public (non-health), Researchers and Academicians
- To enable information dissemination and communication in the fastest way
- Reporting of events happened and to put up the notices for the upcoming events (WGNRR Type)
- Information about the various campaigns
- Provision of links and information of associates
- Digital library / archives

ii) Content:

- Report of past events
- Repository / database of future events
- In a position to give the visitors / other PHM regional circles ideas to the types of campaigns that can be initiated (for those looking for action)[2]
- News about PHM resource persons traveling, meeting etc.,
- Web based campaigns (Eg. Million signature)
- Contact information about the PHM networks, individuals, organizations etc.,
- Links to the partner networks and campaigns and vice-versa (WGNRR type)
- Downloadable PHM publications
- Discussion place (Pinboard?)
- Hosting of background papers and position papers in a downloadable form
- Interactive?
- Updated information

- Medical journal links in our website and vice-versa (?)
- Enabling new contacts through email (secretariat@phmovement.org)
- Usage of the internet facility to overcome the geographical barriers for discussion (the tele-link of the DG debate)

iii) Ways and means

- Not applicable

iv) Context (When and where)

- Continuous updation, but announcements on campaigns and events should be at least 30 days ahead of the event
- Since it is virtual, where does not come into picture

v) The way to go ahead (Some practical aspects both short and long term)

- Any major event / campaign or tour of PHM resource persons to be reported 1 month in advance on the website (Short term)
- Should be made more interactive(Short to middle term)
- More audio/visual/testimonies to be put up to make it more lively (middle term)
- A mention about the old site (pha2000.org needs to be made) (Short term)
- Feedback form to be made more interactive with space provided for them to tell about their organization / country / work etc.,
- E-newsletter to all the people who have signed the feedback form (& probably newsbrief as well)
- Reporting the activities / events from the regional circles
- Provision of links with networked organizations and vice-versa
- The website can be made to automatically detect the region from where they are viewing and accordingly adjust the content / language etc., (long term)
- A counter could be included (short term)

- Provision of a bookmark facility (short term)

- Background and position papers (very important) , as this would be the purpose for which many researchers / academicians would visit the PHM site

- Medical journal links in the website and vice-versa

- Media centre with three clear divisions (middle term)

  - Press releases from the PHM
  - The media coverage of PHM
  - Newsbriefs (also if possible in the long term in regional languages) [1]

- Enabling communication through email (secretariat@phmovement.org)

vi) Measurement indicators:

- Provision for feedback
- How active and live the website is (objective evaluation fron time to time)
- Has much has it stimulated the activities of the movement
- Number of hits on the search engines
- Number of hits on the web-based campaigns (possibly with the help of counters) and the response to the same
- Number of visitors to the PHM website (measured with the help of counters)
- Effectiveness

4. Emails / List Servers (PHA-Exchange)

i) Objectives

- Targeted for digitally enabled, also to some extent digitally marginalized but having a digital conduit. Also for Health professionals, decision makers, development people, even general public as it is an open forum
- To provide an open forum for discussion among the PHM friends and also to provide an open channel for communication (e-mail as well as list server)
- Faster communication (applicable for e-mail)
- To raise issues of common concern
- Mildly moderated communication and discussion forum and accommodation of different views and perspectives

- To sustain the interest of first timers (e-mail)
- As an additional conduit of information about campaigns and events

ii) Content:

- Report of past events
- Universal platform for all issues (health, non-health)
- Information dissemination which can also lead to discussion
- General communication tool for people to get in touch with other
- To send drafts of some of the papers on some issues to enable a discussion and finalization of the PHM position
- Finalization of strategies

iii) Ways and means

- Not applicable

iv) Context (When and where)

- Not applicable

v) The way to go ahead (Some practical aspects both short and long term)

- Sustaining the interest of the first timers
- Regular email newsletter
- Email in the local/regional language (long term)
- The list server to be propagated in all the partner networks and vice-versa
- Extract important information from the list server and then put it on the website and propagate that this information came from the List server
- Any campaigns / events/ awards reported to be projected onto the website

vi) **Measurement indicators:**

- Effectiveness in facilitating decision making
- The relevance of the issues discussed
- The response to the campaign announcements etc.,

5. Charter and publications:

i) **Objectives**

- To propagate the charter and also to project PHM position on various issues
- As a means of enrolling new people into the movement by means of signing up
- As a reference document
- Also places like the universities etc., where the publications could be used as reference documents

ii) **Content:**

- Stand on various issues and the stress on Primary Health Care

iii) **Ways and means**

- As Hardcopies in various languages
- As softcopies in various languages

iv) **Context (When and where)**

- Anywhere

v) **The way to go ahead (Some practical aspects both short and long term)**

- This has been the most popular one for which the PHM website has been visited. Anybody wishing to download the charter must be made to fill up a small online form to enable us to have them as our country contact points (mid term)

- Increasing the number of languages (mid term) [Many states in India only don't have this in their languages]

- A provision may be made to ask the people who download the charter to report back to us as to where and how they used it, if possible, with a report and this can be put up on the website alongside charters, stimulating similar action by others

vi) **Measurement indicators:**

- Feedback forms received
- Requests for hard copies

6. **7. 8 and 9 (Combined) : Active campaigns / word of mouth/meetings/ workshops/ visuals/ performing arts :**

i) **Objectives**

- These are the most effective ways in communicating to the grassroots people
- To propagate the charter and also to project PHM position on various issues
- To provide a platform for the "voices of the unheard" to be heard

ii) **Content:**

- Charter
- Video / performing arts in local language

iii) **Ways and means**

- Meetings at various countries / regions
- In various languages
- Video / performing arts
- Propagation of campaign in the website, Exchange etc.,

iv) **Context (When and where)**

- Anywhere, but strategically covering all the geographic regions

v) **The way to go ahead (Some practical aspects both short and long term)**

- All campaigns / meetings must be given maximum coverage
- Promote / stimulate people of the nearby regions/ countries (if within a region) to join the meetings
- Detailed proceedings of the meetings/workshops to be circulated to the other regions/ PHA Exchange, website etc., to stimulate similar activity in the other regions.

- Copy of the testimonies (if possible as audio and visual aids) to be sent to the website etc.,

David Werner says "**Mass gatherings to be used as organized resistance against global abuse of power** [4]

vi) Measurement indicators:

- The response to a particular meeting
- The number of new people joining the movement etc.,

Broader Issues involved:

For all the above mentioned strategies to happen the following are the broader issues that are involved in making this a success:

1. **Background technical and position papers:** As this is a very efficient tool to make people, policy makers aware of the issues involved and for which PHM fights for, it is very important that the communication group gets full support from the technical resource persons who are working on various issues to contribute regularly to the content of the website, without which all the communication tools would appear very static and does not interest new people coming in , or even the people within the movement would not have specific action items to take the movement forward

2. **Decentralization:** This is another important aspect which comes out of this draft paper. Until and unless the process of communication gets decentralized the movement cannot be taken to the grassroots. So it is very important that in the respective regions/countries/organizations there are some people who think of the communication aspects as well, as decentralization also means that a lot of local content needs to be brought into the movement and taken to the people in their respective regions

3. **Language:** This is going to be one more important issue that would need to be considered while considering the decentralization. The whole movement cannot be stimulated with only English as the language as from our experience till now we have seen that people would go and check the website for charters or testimonies in their languages

4. **Workshops/meetings:** From this paper it comes out clearly that the workshops / face to face meetings are one of the best ways to reach the grassroots. But for this to happen we could not possibly depend on international sort of events/meetings as this would involve huge costs of travel for the resource persons. So efforts should be made to hold regional meetings and then soliciting the local support and then reporting the event back to the secretariat should happen.

5. **Bottom-up approach:** Lots of activities happen and are being conducted by organizations/regions/networks etc,. But none of them get reported. The knowledge remains confined. The people who are involved at the grassroots with their campaigns, issues etc., should report back to the communication circle so that it gets reported to the wider circle and gives ideas to the other people to take up similar activities and also possible join the campaign in solidarity.

References:

[1] PHM secretariat – Prasanna and Ravi Narayan.
[2] Unnikrishnan – Personal communication
[3] Andrew Chetley – Communication matters! – Dated 28.05.2003
[4] David Werner – Communication as if people mattered – Background papers for People's health assembly